DEPARTMENT OF HEALTH

How to Embed Health Equity in Emergency Preparedness

August 2024

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Background

The Minnesota Department of Health (MDH) Emergency Preparedness and Response (EPR) Division contracted with All Clear Emergency Management Group in July 2023 to help identify health equity disparities in health care emergency preparedness across the State of Minnesota. The goal of this project is to help Minnesota Health Care Coalitions (HCC) embed health equity into their plans, practices, and governance structures that aim to protect, maintain, and improve the health of all Minnesotans.

As a culmination of this project, All Clear created this toolkit and provided each region with a written report designed to work in partnership with each other. The regional reports identify best practices and highlight current gaps and areas for improvement in embedding health equity into HCC plans, response actions, membership, governance structures, and other activities. These reports include a list of recommendations for *WHAT* each HCC can do to further health equity-centered planning in their region.

This toolkit was developed to provide HCCs and their members with practical tools and resources for *HOW* they can address the recommendations as outlined in their Regional Report. Therefore, the toolkit was designed to be used in partnership with the Regional Reports, which can be found on the MDH EPR SharePoint Site (https://mn365.sharepoint.com/sites/MDH/epr/hpp/equity).

Toolkit Introduction

This toolkit is designed for Minnesota's Regional Health Care Preparedness Coordinators (RHPCs) and their members to incorporate health equity into their emergency preparedness and response activities. This toolkit will help RHPCs and their members engage with communities most impacted by disasters due to social, economic, and historical conditions; reduce health care disparities; and infuse health equity into day-to-day operations.

The toolkit provides foundational information, practical tools, and resources to proactively incorporate health equity in the daily work of HCCs. These resources are also designed to be beneficial for HCC members.

By using this toolkit, users will be able to:

- Understand what health equity is and why it is important to create an ecosystem around it in their emergency preparedness and response work.
- Identify strategies to improve health equity-centered planning in their work.
- Proactively develop plans, processes, and systems that respond to communities' needs and values.
- Effect changes at the individual, regional, and system levels to improve health outcomes for everyone in their community.

- Be an advocate for health equity and use their platform in collaboration with health care, public health, EMS, and emergency management in their region to help all stakeholders better plan, serve, support, work with, and meet the real-world needs of the whole community.

How to Use This Toolkit

This toolkit is designed to "teach a person how to fish" by helping them continuously advance health equity in their work. Each component can be used independently or as part of the whole toolkit. Users can focus on the components most relevant to their region or work through the entire toolkit from start to finish.

This toolkit has two sections:

- **Section 1** provides foundational information to increase understanding of the landscape of a health equity-centered ecosystem. It guides users in thinking through the process of creating and maintaining a health equity-focused ecosystem in their regional work, both in daily operations and during response efforts.
- **Section 2** and the appendices provide actionable resources, including examples, tools, and references tailored to the work and structure of Minnesota's HCCs. These components can be used to facilitate conversations, incorporate health equity into discussions, and convene workgroups.

The following are navigational tools to help users use this toolkit:

The **Best Practice** icon highlights recommendations for learning about health equity or embedding health equity into the HCC and its membership/work.

The **Activity** icon highlights an activity users can conduct with their HCC and/or their members to include health equity considerations in their work.

The **Health Equity Content** icon highlights definitions and suggested content for HCC and member planning and response documents.

Section 1: The Ecosystem of Health Equity-Centered Planning

Section 1 provides foundational knowledge to help users understand how health equity functions as an ecosystem and how their emergency preparedness efforts contribute to that health equity ecosystem.

This section may present a new framework to consider. Approach this with an open mind and be ready to reframe and relearn how health equity intersects with your daily work as you work through this section.

What is Health Equity?

The Centers for Disease Control and Prevention defines health equity as:

"Health equity is the state in which everyone has a fair and just opportunity to attain their highest level of health. Achieving this requires focused and ongoing societal efforts to address historical and contemporary injustices; overcome economic, social, and other obstacles to health and healthcare; and eliminate preventable health disparities."

- Center for Disease Control and Prevention (CDC)

https://www.cdc.gov/health-disparities-hiv-std-tb-hepatitis/about/?CDC_AAref_Val=https://www.cdc.gov/nchhstp/healthequity/index.html

Add a Definition of Health Equity to HCC Documents.

MDH recommends using the CDC's definition in the box above when defining health equity in planning documents.

Health Equity is Necessary

Research has repeatedly shown that existing social, environmental, systemic, and historical barriers negatively affect some communities and groups more than others. The Department of Health and Human Services (DHHS) Administration for Strategic Preparedness and Response (ASPR) released the updated Notice of Funding Opportunity (NOFO) for Fiscal Year 2024-2029 in May 2024. This NOFO identifies the need for health equity considerations when planning for communities most impacted by disasters and engaging these communities or their representatives in all HCC activities.

"Health equity is at the core of ASPR's Strategic Plan…ASPR's health equity goal is to improve equitable access to and delivery of ASPR services to all members of our communities by making health equity integral to ASPR's organizational readiness and external preparedness, response and recovery activities."

- Administration for Strategic Preparedness and Response (ASPR)

(2024, July). ASPR Health Equity Fact Sheet
Retrieved July 22, 2024, from https://aspr.hhs.gov/newsroom/Pages/HealthEquity-2024.aspx.

The ***Social Determinants[1] of Health*** are the "conditions in which people live, learn, work, play, worship and age.[2]" There is extensive research linking health outcomes to these determinants.

In fact, public health practitioners understand that the social determinants of health are the main influencers of health outcomes.[3] Social determinants of health include five domains[4]:

- Economic stability
- Education access and quality
- Health care access and quality
- Neighborhood and built environment
- Social and community context

"20% of health outcomes are directly related to medical care, whereas 80% of health outcomes are linked to the drivers of health—the socioeconomic, environmental, behavioral, and community factors that impact our lives, livelihoods and health."

- Rachel Nuzum, Corinne Lewis, and Debbie Chang

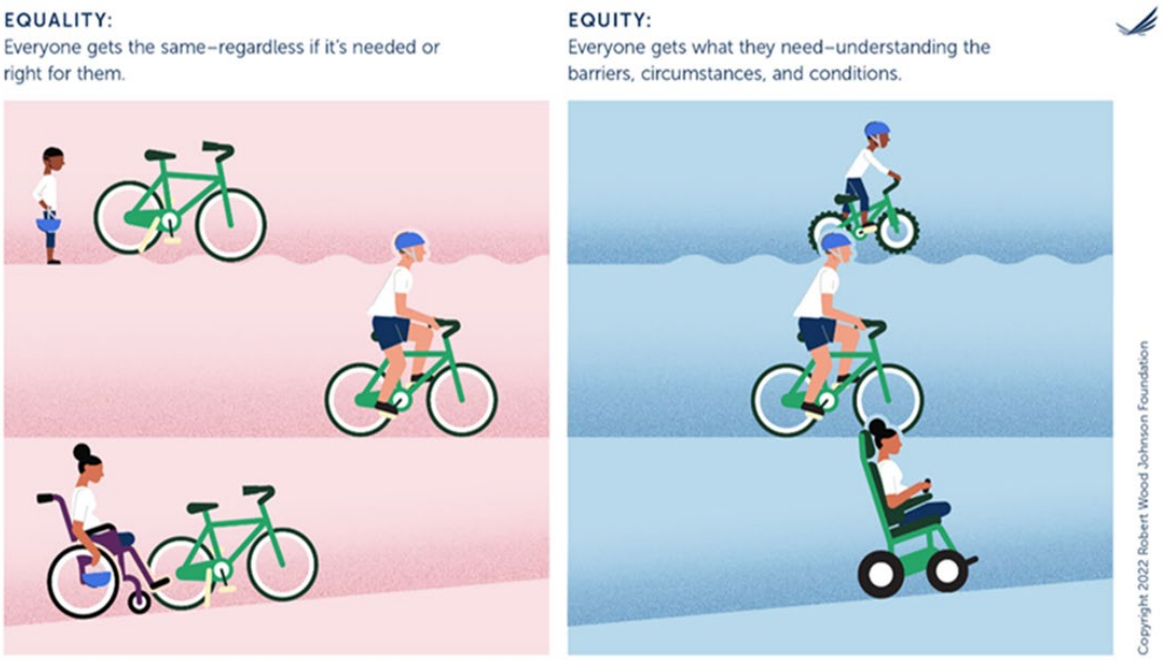
"Measuring What Matters: Social Drivers of Health," To the Point (blog), Commonwealth Fund, Nov. 2, 2021. https://doi.org/10.26099/q0pa-xf79

Social determinants of health also include government policies, regulations, and laws. HCCs can identify the social determinants of health for communities in their region. They can use these to prepare and respond in ways that account for disparities created from these factors that are outside of a person's or community's control.

Learn More about Health Equity
The Regional Health Equity Network (https://www.health.state.mn.us/communities/practice/equityengage/networks/index.html) offers customized Health Equity 101 Trainings to partners and members upon request.

To request a training, use their Training and Assistance Request Form.

Health Equity is Different Than Equality

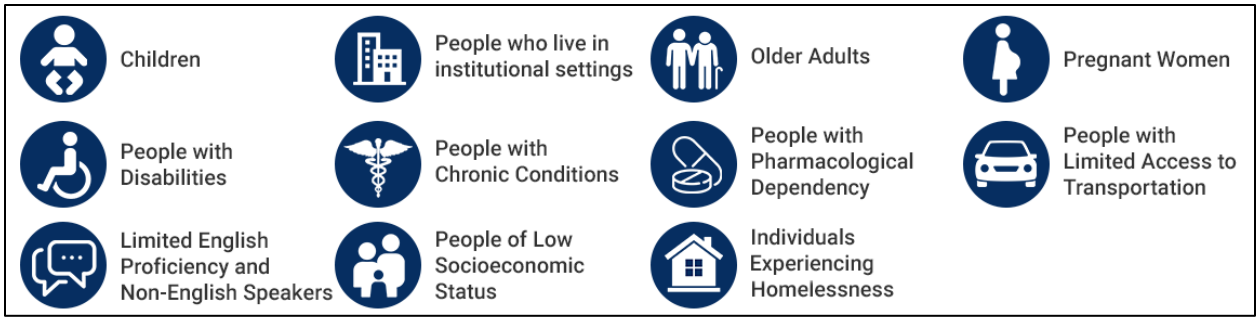


[5]**Equality** assumes that everyone has the same needs. In the figure to the left, equality is illustrated by everyone getting the same kind of transportation (a bike), even though only one person can use the bike. The other people are left behind and the other bikes are wasted.

Equity recognizes the reality that people have different needs and considers what is needed to meet those needs. In the above figure, equity is illustrated by everyone getting the kind of transportation that fits their circumstances. Each person now has exactly what they need to advance.

Access and Functional Needs Are Part of Health Equity

Access and functional needs (AFN) is a concept that is used to ensure health equity in emergency preparedness and response. It focuses on people who are at higher risk during emergencies. ASPR defines "at-risk" populations as people who have temporary or permanent needs that may interfere with their ability to "access or receive medical care before, during, or after a disaster or public health emergency."[6] At-risk populations include, but are not limited to, children, pregnant people, older adults, people with disabilities, people from diverse cultures, people with limited English proficiency, people with limited access to transportation, people with limited access to financial resources, people experiencing homelessness, people who have chronic health conditions, and people who have pharmacological dependency.[7]



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Health Equity is Everyone's Responsibility

The health of individuals is impacted by the communities in which they live and the systems, structures, and policies that influence those environments. Creating a robust health equity ecosystem requires dynamic collaboration and cooperation.

Since health inequity does not have one simple cause, there is not one simple solution. Health inequities are complex, so health equity work cannot only happen at the individual, health care facility, or local public health levels. Solutions require a holistic approach whereby every level (individual, facility, regional, state, and federal) works to dismantle health inequities.

Human beings do not exist in silos. A human's health is interconnected with their community and their social networks. Inequities are interwoven into the systems, policies, procedures, and norms within our society. Therefore, it is everyone's responsibility to create a vibrant ecosystem of health equity.

Who is Most Impacted by Disasters?

The CDC's WONDER database found:

- 1 in 3 Americans experienced a disaster in the Summer of 2020. Of those who applied for assistance, low-income applicants were 2x more likely to be denied FEMA housing assistance than non-low-income applicants.
- Older adults have a 3.84-fold increase in mortality caused by all natural hazards compared to those under age 60.
- American Indians/Alaska Natives have the highest mortality rate of any racial/ethnic group and are particularly impacted by excessive cold.

- Dr. Lori Peek, Director of the Natural Hazards Center during the US House of Representatives Committee on Homeland Security Hearing "Ensuring Equity in Disaster Preparedness, Response, and Recovery" (Oct 27, 2021)

https://www.congress.gov/117/meeting/house/114141/witnesses/HHRG-117-HM00-Wstate-PeekL-20211027.pdf

Why Think About Health Equity as an Ecosystem?

MDH uses the metaphor of an ecosystem to help individuals think about and understand the intersectionality of health equity.

A healthy ecosystem is an interacting group of various species that share a physical environment. When one element of a healthy ecosystem is removed, the damage to the ecosystem can be significant. Healthy communities are similar and depend on shared systems, structures, and environments to support community members.

Viewing health equity as an ecosystem illustrates how actions to improve community health are directly linked to a community's ability to prepare for, respond to, and recover from disasters.

What Happens to a Health Equity Ecosystem During a Disaster?

Disasters change the health equity ecosystem. Every state has been affected by at least one disaster, with costs equaling or exceeding $1 billion in damages (adjusting for inflation) since 1980. Every county (or county equivalent) in the U.S. has experienced some loss due to natural hazards during the period from 1960 to 2019.[9] Natural hazards create changes in a community's physical and social environment and alter the ecosystem.

Disasters worsen existing inequities. Research shows that people who experience one or more forms of marginalization, including those considered at-risk in the access and functional needs framework, are:

- Less likely to have access to the resources to live or relocate to places that are safer from environmental hazards.
- More likely to experience severe physical and mental health outcomes after a disaster.
- More likely to be displaced.
- More likely to experience lengthy and uneven recovery processes.[10]

These communities often have fewer resources which makes it more difficult to prepare for, respond to, and recover from disaster.

Disasters impact communities differently. Communities have varying levels of resilience to disasters, often influenced by factors beyond their control, such as location, hazard type, population density, and social determinants of health. By viewing health equity as an ecosystem of interconnected people and needs, we can better prepare for and respond to disasters effectively.

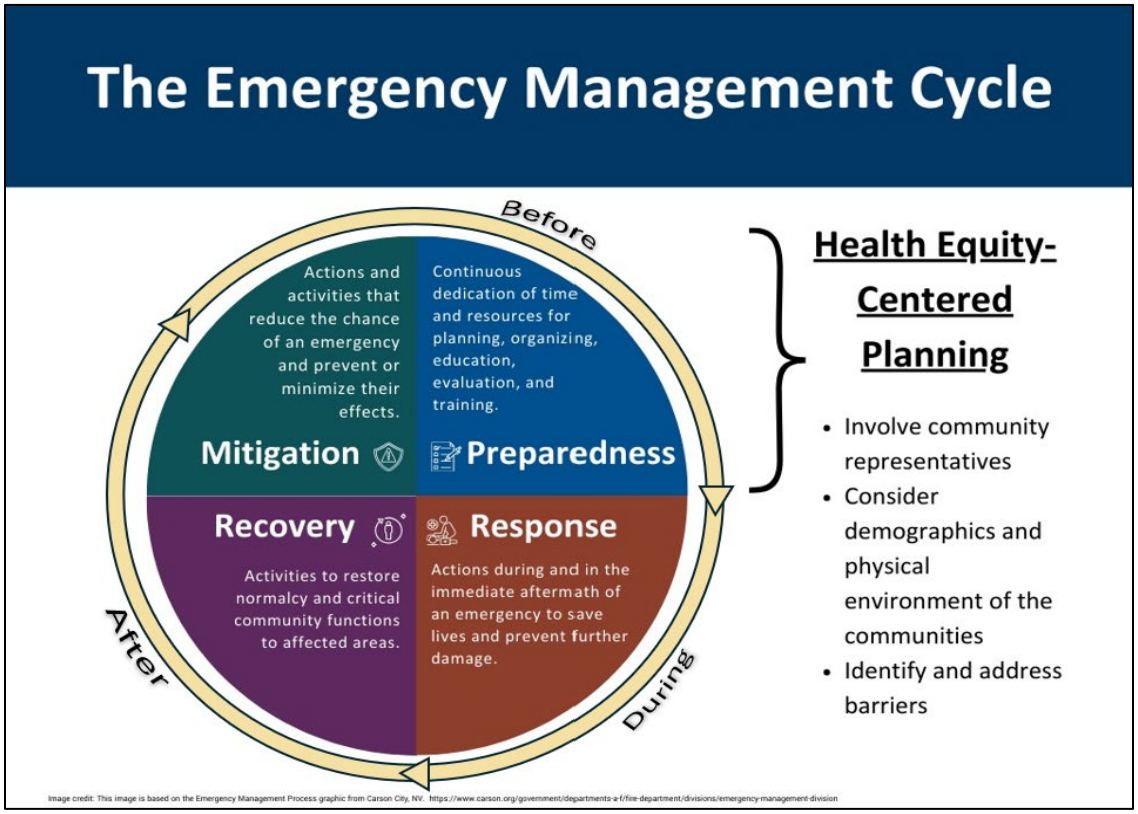
"According to a 2018 study, White Americans living in counties that received disaster aid gained over $100,000 in wealth compared to White Americans living in counties that did not experience a disaster. In contrast, Black and Latino Americans in areas that received disaster assistance lost thousands compared to their peers that had not experienced a disaster. A person's zip code or

skin color should not affect how he or she fares in a disaster, but this is exactly what happens. Low-income and rural communities are especially at risk."

-Dr. Lori Peek, Director of the Natural Hazards Center
US House of Representatives Committee on Homeland Security Hearing
"Ensuring Equity in Disaster Preparedness, Response, and Recovery" (Oct 27, 2021)
https://www.congress.gov/117/meeting/house/114141/witnesses/HHRG-117-HM00-Wstate-PeekL-20211027.pdf

Health Equity Starts with Emergency Preparedness

Emergency Management professionals are familiar with the Emergency Management Cycle and its phases: Mitigation, Preparedness, Response, and Recovery. Health equity-centered planning begins before an emergency occurs and continues throughout the emergency management cycle. There is an opportunity to engage with community members, assess demographic data, and identify barriers to a successful response.



BEST PRACTICE

Emergency preparedness planners, including HCCs, should work with communities most impacted by disasters to develop emergency preparedness and response plans. Health equity-centered planning that draws on the expertise and experience of communities most impacted by disaster sets users up for success to serve their whole community.

Health Equity Carries Through to Response and Recovery

The Federal Emergency Management Agency (FEMA) is focused on reducing barriers and increasing opportunities so all people, including those from communities most impacted by disasters, are better able to access response, recovery, and resilience programs.

"Established patterns of public health emergencies tend to disproportionately impact communities that experience health disparities and inequities. Therefore thorough, systematic attention should be given to health equity considerations in all coordination activities and Lines of Effort, in every information-sharing process, and during every Operational Phase.

In addition to descriptive population health data, health equity considerations should include consideration of how social policies, structures, conditions, and characteristics defining specific places may create differences in exposure risks, social vulnerability, and resilience among diverse populations in emergencies."

-Federal Emergency Management Agency (FEMA)
https://www.fema.gov/es/node/653135

As previously stated, regulatory agencies are beginning to acknowledge health equity and are attempting to address it. The Joint Commission[11] and Centers for Medicare and Medicaid (CMS)[12] have promoted health equity considerations. ASPR's most recent HPP FY24 NOFO identified best practices for incorporating health equity considerations into HCC emergency preparedness. For more, see Appendix M.

How Can the RHPCs and Their Members Foster a Health Equity Ecosystem?

Creating a vibrant health equity ecosystem requires dynamic collaboration and cooperation. Our health is deeply interconnected with our community and social networks, yet inequities are woven into the fabric of our systems, policies, procedures, and individual lives.

Minnesota's HCCs and their members are uniquely positioned to be at the heart of the effort to build a health equity ecosystem. Their collaborative structure and diverse membership represent a network of interconnected health care and emergency response systems. With a foundation built on cooperation, HCCs are ideally suited to provide a platform for discussing and advancing health equity across each region. As local public health and other entities work to promote health equity, HCCs can serve as a vital bridge, connecting health care partners, communities most impacted by disasters, and emergency preparedness and response efforts.

This is good news for the RHPCs. It means they can have a direct, positive impact on their region's health equity ecosystem, and they can have a positive impact on the health and well-being of those living in their region. Users of this toolkit can be equity advocates by using this toolkit to bring health equity into the things they already do: fostering connections among

members, sharing information, enhancing coordination, preparing for resource coordination, proactively planning for emergencies, and hosting training and exercises.

Section 2: Actions to Create a Thriving Health Equity Ecosystem in the Region

Section 2 describes actions and provides tools, best practices, checklists, and examples for RHPCs and their HCC members to center health equity in their existing work. The items in this Section and the appendices are practical tools and resources for *HOW* to address the recommendations as outlined in their Regional Reports. HCCs can select the items that best address the identified gaps.

Action 1: Understand the Region's Communities Most Impacted by Disasters

HPP Activity 2- Assess readiness: Assess your region to identify populations most impacted by disasters (Appendix B, Page 87-89 of HPP FY24 NOFO)

Fundamentally, health equity-centered planning promotes incorporating input from those who will be served or affected by your planning efforts. It is essential to understand the diverse makeup of your community and to maintain strong relationships with individuals from various cultures, traditions, experiences, and health-related needs, especially with the leaders and organizations that represent them.

This action is for the HCC and its members if…

- ☑ Your membership doesn't look like your community.
- ☑ Your HCC membership doesn't represent the diversity within your community.
- ☑ Census reports and public data are limiting.
- ☑ You want to be more effective in engaging your community.
- ☑ You want to include community members and make an impact.

If any of these conditions apply, take steps to perform Action 1. Suggested steps are outlined below.

Connect with the Regional Health Equity Network
Register for the region's Regional Health Equity Network to connect with health equity planners, colleagues, and professionals in the region and encourage HCC members to do the same.

Leverage Data

Data can provide valuable insights and a rich portrait of the community – what it looks like, how it compares to others, and how it has changed over time. Analysis can turn raw data into actionable information that can be used to guide preparedness and response efforts.

Use Data to See Who Is in the Community

There are a variety of data sources that can help. Here are a few suggestions:

- ☐ Local and state public health partners have health equity experts for technical assistance.
- ☐ See Appendix O for some useful data sources.
- ☐ Leverage data to inform Risk Assessments.
- ☐ Review the Regional Profiles (included in the Regional Reports).
- ☐ Use results to Infuse Health Equity into HCC and Membership Plans and Planning Process.

Use Regional Profiles

MDH has provided each HCC with a Regional Profile included in the Regional Report. The Regional Profile is a short, quick-reference document that synthesizes information from federal, state, and local sources, including data such as population demographics (with an emphasis on marginalized groups in the region); common languages; the prevalence of housing, internet, and transportation needs; and immigrant and refugee populations in the region.

Use the Regional Profile

The Regional Profiles offer an easy way to learn the basics of the community. As users read the HCC region's profile, consider the following questions:

- ☐ Is there new information in this profile?
- ☐ Does the HCC's membership match the demographic information? If not:
  - What gaps exist?
  - Who is missing from the HCC's membership?
  - How can the HCC engage with community members?

Action 2: Assess Health Care Coalition Systems and Structures

RHPCs can establish a health equity ecosystem within their existing HCC system and structures. HCCs are inherently collaborative, bringing together members from both health care and emergency response sectors. By leveraging these existing resources and connections, RHPCs can enhance and expand inclusive planning and response efforts across their region.

Apply Inclusive Communication Strategies

Inclusive language and communication strategies are defined by making sure information is accessible to the whole community. Examples include having emergency messages translated into other languages spoken within the communities, using plain language, having culturally relevant media, and accessibility (such as American Sign Language, digital accessibility, and

tactile formats). Inclusive communication breaks down barriers and builds trust and mutual respect among HCC members and community representatives.

Inclusive Communications
Incorporating inclusive communication methods ensures all members, regardless of background or identity, feel welcomed, valued, and able to participate. These methods help create an environment where everyone is respected and considered. See Appendix C for some strategies.

Review the HCC's Governance Structure

HPP Activity 1: Update Governance to include membership organizations that can help address disparities for communities most impacted by disasters (Section 1, Page 16-18 of HPP FY24 NOFO)

Health equity-centered principles can be added to HCCs and other organizations' governance structures. This toolkit provides some examples of ways to incorporate health equity into governance structures by adding content to mission statement(s) and describing the community members that may need to be engaged. See Appendix D: Governance Improvement Flowchart.

Health Equity-Centered HCC Mission Statement Example
The [organization] strives to embed health equity principles, considerations, and best practices into all aspects of the [organization's] work, systems, and structures. To that end, [organization] will support fostering a collaborative environment among diverse stakeholders to address systemic barriers and disparities in healthcare access, delivery, and outcomes in preparing for, responding to, and recovering from an emergency. Through education and innovative solutions, [organization] will strive to ensure that every individual in the region, regardless of race, ethnicity, socioeconomic status, gender, sexual orientation, disability, or geographic location, has the resources and support they need to access health care services during an emergency.

Update Organizational Structures
Use data to identify communities specific to the region that have been historically, economically, and systematically marginalized and begin to engage with them. HCC's organizational structure can be updated to reflect these changes. See Appendix E for a sample organizational structure.

Update Meeting Agendas

HCC meetings can be an opportunity to include health equity discussions in a meaningful way. Meetings can be structured to include health equity training, education, and considerations. HCCs can model this behavior for their members to emulate. Meetings can provide members

with an arena to share their work, knowledge, challenges, or barriers related to health equity in their region during their already scheduled discussions.

Incorporate Health Equity into Meetings

Adding health equity to meetings does not necessarily mean adding new meetings. Consider some of these suggestions:

- ☐ Work through this toolkit and engage HCC members in some of the activities suggested.
- ☐ Promote or host health equity training opportunities (such as those from the Regional Health Equity Networks).
- ☐ Identify potential members based on data. Use the data collected above to assess the HCC's membership and discuss potential outreach for new members.
- ☐ Incorporate member or new member spotlights. Invite HCC members to share their successes and barriers with health equity planning or community members as an opportunity to learn about them and their culture.

Increase Member Diversity and Recruitment

Using the HCC's Regional Profile and other data collected, users may identify one or more communities that are missing from the HCC's table. The HCC may want to address these gaps by communicating with and recruiting new members to the HCC.

Recruit Members that Mirror Communities Most Impacted by Disasters

Planning and response work is enhanced when more voices are at the table. This recruitment process can be incremental. Discuss membership within the HCC to select one group or choose one recruitment strategy as outlined in Appendix F.

Who Do You Know?

Engaging new members may not be difficult. Identify who already has connections within the communities that the HCC or HCC members want to engage. Consider:

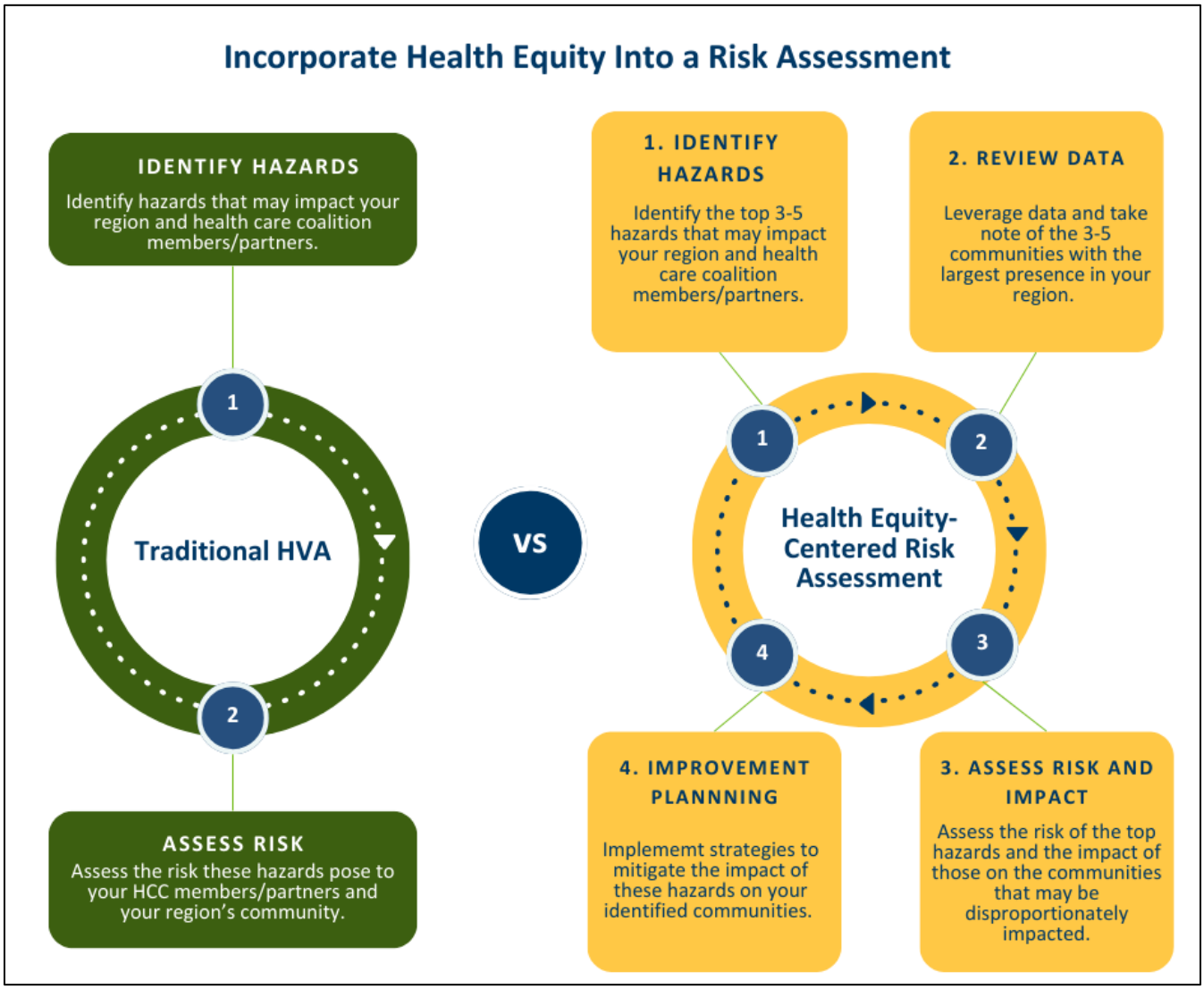
- ☐ Local public health through initiatives such as Women, Infant, and Children (WIC) programs or Immunization efforts.
- ☐ Federally Qualified Health Centers (FQHCs) or Community Health Clinics.
- ☐ Religious organizations or houses of worship.
- ☐ Community-based organizations such as Meals on Wheels or Cultural Centers.

Action 3: Add Health Equity to Preparedness Efforts

Build on Risk Assessments

HPP Activity 2: Conduct an HVA (Section 2, Page 19-23 of HPP FY24 NOFO)

As mentioned in Section 1, incorporating health equity begins in the preparedness phase of emergency management. Assessing and identifying the hazards that may impact the user's region is a standard practice in emergency management. HCCs may call this a risk assessment, a Hazard Vulnerability Analysis (HVA), a Joint Risk Assessment (JRA), or another similar term. But the goal is the same: a prioritized list of hazards that can be used to guide their emergency preparedness activities.



Health equity can be improved by building on the results of a risk assessment.

Step 1: Identify top hazards

Conduct the usual HVA processes to identify 3-5 of the top hazards in the region.

Step 2: Review data

Review regional data related to social vulnerability, demographics, economic, and societal factors. Take note of the communities most likely to be impacted by disasters in the region.

For a Minnesota-specific HVA tool that can help with Steps 1 and 2, see the Equity HVA tool, can be found on the MDH EPR SharePoint Site (https://mn365.sharepoint.com/sites/MDH/epr/hpp/equity).

Step 3: Assess Risk and Impact

Compare and analyze the information collected in Step 1 and Step 2. Assess:

- Which communities are most impacted by each hazard?
- What are the factors that contribute to the impacts made by these hazards?

Users may notice during this discussion that some hazards impact some communities more than others. Users may also notice that some hazards may not apply to certain groups. All of this is important to capture in the analysis.

Step 4: Improvement Planning

Now that users have discussed the impact of the top hazards on communities most impacted by disasters in their region, it's time to identify action items. What can the HCC do to:

- Mitigate the impact on these communities?
- Prepare these communities for the event or its expected impact?
- Update response procedures?
- Anticipate the impact during recovery?

Nothing about us without us.
The motto "Nothing about us without us" relies on the principle of participation and has been used by Disabled Peoples Organizations as part of the global movement to achieve the full participation and equalization of opportunities for, by, and with persons with disabilities. This motto can be applied to users' risk assessment as well. A risk assessment is best when it involves a diverse group of people from a variety of roles and experiences. In addition to HCC members, consider additional community partners or service organizations such as Community Health Workers (CHWs), Tribal Nations, Regional Health Equity Network representatives, Federally Qualified Health Centers (FQHCs)/Community Health Clinics, those with experience in community engagement, and those with experiences (lived and learned) different than users' own. They can speak best to their community's anticipated impact.

An Example

Below is an example that walks users through the above process, step-by-step.

Step 1: Identify Top Hazards

You live in a region where tornadoes are common, and "tornado" is listed as the top hazard in your region's risk assessment.

Step 2: Review Data

Based on a data analysis, you know your region has a significant population of the following groups:

- The unhoused/homeless populations.
- Limited/non-English speaking groups (Spanish as the most prevalent).
- Limited, unreliable, or no broadband internet access.
- One large university with student housing.
- Residents aged 65 and older.

Step 3: Assess Risk and Impact

Based on this demographic information, your HCC invites representatives from a faith-based community serving the Spanish-speaking population, the local homeless shelter, the local University, and the local senior center to participate in the risk assessment process. You explain to the group that a tornado is a top risk for your region.

First, you ask, "What would the impact of a tornado be on each population?"

The homeless shelter representative states that the people they serve who are in the shelter at the time would hear the warning and have a safe space to take shelter. However, those on the streets or in their car may not hear the warnings (either by sirens, alerts sent by a mobile app, or reverse 911). They also may not have access to a safe shelter area.

The representative from the senior center agrees. The seniors they serve who may be at their center for program activities would be alerted by staff and would have a safe space to shelter. Those not at the center or during night hours may not hear the alert. Some of them do not have cell phones for app-based alerts. Some have hearing disabilities.

The representative from the faith-based organization serving the Spanish-speaking community adds that messages and instructions in English may not be understood by this group. This same concern could apply to those who speak the other most common languages in the region, which are Hmong and Somali.

The University representative notes that students are typically savvy with technology. However, many of them are not from the local area, and they may not have signed up for local alerts. Students also may not take appropriate action based on the alerts or know safe shelter spaces in the variety of buildings at the University.

Step 4: Improvement Planning

Based on this conversation, the group discussed the following action items.

Action Item	Responsible Agency
1. Assess the alert systems and siren systems used locally. What response partners receive these messages? Are they offered in languages other than English? Are instructions written in an easy-to-understand format? What methods can be used to alert those without cell phones or those with hearing disabilities?	Emergency Management in coordination with Public Health and the HCC
2. Create a response process to pull demographic data about groups likely to be impacted based on the location of the tornado.	HCC
3. Create a response process to convene community-based organizations that serve those groups to obtain information on specific resource allocation needs, support, and cultural considerations of the groups identified. Share that information with stakeholders as appropriate.	HCC
4. Update alert system protocols and messages based on this assessment.	Emergency Management
5. Provide tornado warning and response training. Connect with community representatives to schedule and conduct training appropriate for the people they serve.	Emergency Management
6. What else can the HCC do to better support the whole community in this response? Brainstorm ideas.	HCC

Infuse Health Equity into HCC Membership Plans and Planning Processes

Proactively embedding health equity considerations into the planning process fosters a thriving health equity ecosystem. Relationship-building among response and recovery organizations is built during the planning process. Close relationships cultivated during the planning process translate into better coordination and teamwork in emergencies.

A Diverse Planning Team
Toolkit user's planning team can draw from various groups that have a role or stake in emergency response. In addition to responders, consider adding those communities that would be most impacted to the planning process.

Add to the HCC's Preparedness Plan
If HCC and/or HCC members have worked through the actions above, they can add their results to their HCC's Preparedness Plans. Consider including:

- ☐ HCC's definition of Health Equity. MDH recommends using the CDC definition.

- ☐ Outreach and member recruitment strategies from Increase Member Diversity and Recruitment.
- ☐ More information about the populations specific to the region from Leverage Data.
- ☐ Results from the Risk Assessment.

Having a Response Plan and associated Annexes with built-in health equity considerations creates a ripple effect for ensuring health equity is considered when an emergency happens. For help embedding health equity in user's plan writing, please see Appendix B.

Update Response Plan and Annexes

Preparedness actions that are taken should correspond to HCC and/or the organization's Response Plan and associated Annexes. Consider including:

- ☐ Relevant results from the Risk Assessment to the plan's Situation and/or Assumptions sections.
- ☐ Procedures for Communication and Notification or Information Sharing to include applicable Inclusive Communication Strategies.
- ☐ Appropriate Roles and Responsibilities for groups that have been historically, economically, and systematically marginalized as determined by the HCC.
- ☐ Methods to add health equity into Training, Education, and Exercises.
- ☐ What resources does the HCC have or coordinate for events? How can the HCC make the distribution of these resources more equitable?

For checklists to help think more about this, please see Appendix A and B.

Action 4: Activate Response Plan and Associated Annexes

HPP Activity 3 Plan and implement: Update Response Plan (Section 3.3, Page 27-29 of HPP FY24 NOFO)

When the time comes, the HCC's Response Plan and associated Annexes will be activated per their process. This is the time to implement inclusive response strategies.

Use Essential Elements of Information (EEI)

When sharing information amongst HCC members and stakeholders, it can be crucial to ensure information is accurate and inclusive. See Appendix G.

Job Action Sheets for a Response

Job Action Sheets (or job descriptions for HCC's response structure) help response personnel function in roles that are not their day-to-day roles. By assigning health equity into Job Action Sheets or other response checklists, the HCC and their members can ensure health equity is considered throughout the response.

Embed Health Equity in Job Action Sheets

There are two opportunities to incorporate health equity in the incident Command System (ICS) or other response structure:

- ☐ Create a Health Equity Officer or other appropriate title within the Incident Command System (ICS) structure to make sure health equity is part of a coordinated response. See Appendix H.
- ☐ Add tasks or actions for the Liaison Officer to connect with Community Organizations to understand resource needs and information sharing needs of the whole community.

Action 5: Recover from an Incident

HPP Activity 3 Plan and Implement: Develop or update a Continuity and Recovery Plan (Section 3.4, Page 33-36 of HPP FY24 NOFO)

Weaving health equity considerations into the recovery phase can ensure that systems and resources are restored more efficiently and are stronger for the whole community. For HCCs, recovery efforts will likely involve operations similar to their day-to-day activities, such as information sharing and providing technical assistance.

Recovery should be considered from the outset of an incident and can be bolstered by planning efforts during non-emergency periods. Planning for recovery ahead of an incident allows for the opportunity to outline how the HCC will restore systems and resources relative to stakeholder operations, and how to engage diverse populations and support the entire community's recovery and restoration.

For a checklist to guide users through incorporating health equity into the recovery phase, please see Appendix I.

Following an incident, the HCC may conduct a debrief to reflect on an event, including acknowledging successes and challenges during the response. Involve the communities and populations that were most impacted by the event in the After Action Report. Together, develop an improvement plan outlining how the HCC and its members will be accountable for reporting back to these communities. Using the After Action Report and improvement plan, the HCC and its membership can identify and develop new strategies to use in future responses.

Expand the Debrief

Just like a diverse planning team leads to a more successful response, collecting diverse perspectives and experiences during a response can provide more inclusive areas for improvement. Consider inviting community organizations that work with or represent impacted populations (e.g., senior populations, disability organizations, faith-based organizations, etc.) to an event debrief.

Action 6: Train and Educate

HPP Activity 4 Exercise and Improve: Plan and Conduct Exercises (Section 4, Page 36-39 of HPP FY24 NOFO)

HCCs play a key role in providing training and education for their members. They can strengthen the effectiveness of health equity considerations by helping their members better understand why it matters and how to think about engaging in the process.

Educational Resources

This toolkit provides a list of educational resources that can be used by the RHPCs and their members. Consider:

- ☐ Requesting training from the Regional Health Equity Network. To request a training, use their Training and Assistance Request Form.
- ☐ Providing the list of Educational Resources in Appendix N to membership.
- ☐ Sharing the stories collected during this project and included in Appendix P. Hear from real Minnesotans and see how individual experiences in health equity form the tapestry of a community's identity.

Action 7: Design and Conduct Inclusive Exercises

HPP Activity 4: Plan and Conduct Exercises (Section 4, Page 36-39 of HPP FY24 NOFO)

Exercises are a crucial tool for testing response plans and building confidence among those involved in emergency response. By incorporating health equity considerations into these training and exercise activities, participants can better understand and address the diverse needs of the community, leading to more effective and inclusive responses during actual events.

Exercises That Mirror Real-Life

Make exercises more realistic and inclusive. Consider:

- ☐ Create scenarios that involve input from, and include, the populations identified as most negatively impacted in Risk Assessments.
- ☐ Review the Exercise Design and Conduct checklist in Appendix J.
- ☐ For some draft exercise injects, see Appendix K.

Take This Opportunity

A thriving health equity ecosystem is not easy, but it is important. HCCs and their members play a pivotal role in advancing perceptions about health equity and can implement actions (like suggestions outlined in this toolkit) to improve health equity in their region and improve health outcomes during emergencies for their whole community.

Health Equity Champions advocate for the principles and best practices within their region and among their stakeholders to create a healthier ecosystem for their community. Learn more about becoming a Health Equity Champion in Appendix L.

Appendix A: Health Equity Planning Process Assessment

HPP Activity 2 Assess Readiness: Assess your region to identify populations most impacted by disasters (Appendix B, Page 87-89 of HPP FY24 NOFO)

This appendix can serve as both a guide for fostering discussion, connection, and collaboration during regular membership meetings and as a resource for members to enhance their individual health equity efforts. The assessment is meant to support engagement with a more inclusive, holistic approach to planning for emergencies across the diverse stakeholders involved in traditional emergency preparedness.

Theme 1: Who lives, works, and plays in the region?

Select the HCC's Stage of Implementation of Each Practice	In Progress	Planning to Do	Not Planning to Do	Unsure
Identify who makes up regional communities. Communities in the region have been identified, including the various access and functional needs, cultures, languages, and leaders that can help inform medical and public health emergency plans and responses. The HCC understands who makes up regional prison populations, congregate care populations, and the people experiencing homelessness populations. This information is mapped or written in a guiding document for planning purposes.				
Identify the leaders/trusted community members within regional communities. Trusted leaders and community members within identified communities have been engaged to build strong relationships. If these leaders or community members have not yet been identified, the HCC is actively working to identify and connect with them to plan collaboratively with specific communities, rather than planning on their behalf.				
The HCC has identified the values and norms of the cultures within regional communities. The HCC respects and has systems in place that allow for norms to be different and varied across cultures. The HCC has systems and policies in place that make this knowledge actionable in plans and responses.				

Select the HCC's Stage of Implementation of Each Practice	In Progress	Planning to Do	Not Planning to Do	Unsure
The HCC has established processes to identify and incorporate the cultural practices of the communities it serves. These processes are documented, and staff are trained and empowered to apply them in their day-to-day work. Please list the written processes that identify cultural practices and ensure this is included in plans.				
Notes:				
The HCC has identified which communities were the most negatively affected by recent disasters/emergencies. This information is mapped by geographic location and by job type, culture, language, and/or socio-economic status. Please list the populations in the HCC's jurisdiction that were most negatively affected.				
Notes:				
The HCC is working closely with communities most adversely affected by disasters to improve health outcomes in future events. The HCC has plans, processes, and systems in place and written down that are centered around inclusive planning and response best practices.				
The HCC has identified places, locations, and times that work best for community members. This includes both planning for the needs of future responses, such as the best times and trusted places to host vaccination clinics, as well as built-in structures to meet with, and learn from community members in advance of a public health and medical emergency. These details have been written in HCC plans.				
Governance and leadership staff are trained on regional community composition. They recognize the importance of this knowledge and know how to use it to enhance their work and deliverables, both in routine operations and during emergency responses.				

Select the HCC's Stage of Implementation of Each Practice	In Progress	Planning to Do	Not Planning to Do	Unsure
HCC membership and internal staff are trained on regional community composition. They recognize the importance of this knowledge and know how to use it to enhance their work and deliverables, both in routine operations and during emergency responses.				

Theme 2: What does the community look like?

Select the HCC's Stage of Implementation of Each Practice	In Progress	Planning to Do	Not Planning to Do	Unsure
Determine what the community looks like. Map areas of different demographic features, such as income level, housing type (i.e., single-family or high density), transportation route access, or average age. Overlay with areas where the HCC hosted vaccine and testing clinics. What discrepancies exist? The HCC has plans in place to resolve those discrepancies for future events.				
Notes:				
The HCC knows the areas and the people most at risk for negative health outcomes during a disaster or disruption. The HCC has plans in place to provide extra resources and support to those areas and/or communities.				
Determine what resources the community needs to be successful. The HCC has asked regional communities what they need to be successful, and has processes, plans, and systems in place to provide these communities with the resources and needs identified. Please list the resources community members identified and/or resources noted.				
Notes:				

Select the HCC's Stage of Implementation of Each Practice	In Progress	Planning to Do	Not Planning to Do	Unsure
Identify which relationships the HCC needs to build to be successful. Have these relationships been identified? Have respected community leaders/persons been engaged? Is the HCC maintaining those relationships on blue-sky days? Has the HCC done the work before an emergency to incorporate community leader/member expertise during gray or black sky days? Has the HCC worked with them to identify what their roles/responsibilities will be during a response? Please list the best methods to obtain expertise from leaders of the community members most impacted by previous emergencies (e.g., lessons learned).				
Notes:				
Formalize processes for what to do with the information received and how that information will be used to improve policies, procedures, plans, and systems moving forward. Is there a clear method for communicating this information to the communities the HCC is trying to intentionally serve?				

Theme 3: What are the resources, resource shortages, communication, and information-sharing opportunities to improve regional efforts?

Select the HCC's Stage of Implementation of Each Practice	In Progress	Planning to Do	Not Planning to Do	Unsure
Identify the access issues/shortcomings that populations disproportionately impacted by recent emergencies/disasters experienced. Consider: access to vaccines, medical services, access to pharmacy services, access to behavioral health and mental health support services, access to substance use support services, access to stable housing, and access to food/grocery stores, and access to translated materials.				

Select the HCC's Stage of Implementation of Each Practice	In Progress	Planning to Do	Not Planning to Do	Unsure
The HCC talks to community members/leaders in areas where access issues have been identified to identify community needs and how they would like improvements to be made. Processes are in place to use community feedback.				
Notes:				
Determine where to allocate resources and services based on the areas with the greatest need for them.				
Notes:				
Resources supporting cultural competency and health equity efforts have been identified. These resources are accessible and regularly referenced by all staff and members of the HCC.				
Determine planning opportunities to improve cultural considerations. The HCC has identified and documented policy-level shortcomings. Plans are in place to improve these shortcomings moving forward.				
When planning response events, systems and processes are in place to ensure these are community-informed plans. For instance, when organizing a vaccine clinic, there is a process to engage with the target audience in advance, allowing for adjustments to the clinic's location, times, dates, and other details based on community feedback. Please list the process or systems used for community-informed planning.				
Notes:				
Systems are in place to gather information from communities and community members, which is then used to continually refine and improve response efforts and resource support. Please list the systems the HCC uses to collate community-specific information for response efforts.				

Select the HCC's Stage of Implementation of Each Practice	In Progress	Planning to Do	Not Planning to Do	Unsure
Notes:				
Consider where the HCC can embed feedback loops processes to ensure plans are being made and implemented with communities, not for communities.				

Appendix B: Response Plan Writing Checklist

HPP Activity 3 Plan and Implement: Update Response Plan (Section 3.3, Page 27-29 of HPP FY24 NOFO)

The checklist below provides a series of questions to ask during the response plan writing process. The suggestions provided here may not be applicable to all HCC document types and are not meant to be an inclusive list.

Activity	Yes: Included in Plan	No: Add to Plan	No: Won't Add to Plan	N/A
General				
The plan is in a format and language appropriate to users.				
The plan's language is inclusive (see Apply Inclusive Communication Strategies).				
The plan was drafted, edited, and approved by a diverse stakeholder group (see Action 2: Assess Health Care Coalition Systems and Structures).				
Introduction (Purpose, Scope, Situation, and Planning Assumptions)				
The plan identifies communities most impacted by a disaster (see Action 1: Understand the Region's Communities Most Impacted by Disasters).				
The plan refers to demographic and community data, including but not limited to their Regional Profile (see Action 1: Understand the Region's Communities Most Impacted by Disasters).				
The plan describes how health care, public health, social service providers, and/or community health workers that support communities most impacted by disasters have been engaged in mitigation, preparedness, response, and recovery efforts (see Action 3: Add Health Equity to Preparedness Efforts, Action 4: Activate Response Plan and Associated Annexes, and Action 5: Recover from an Incident).				
The plan identifies cultural norms, considerations, and languages for communities in the region that may be served or impacted by the plan.				
The plan identifies anticipated barriers to access for communities most impacted by disasters.				

Activity	Yes: Included in Plan	No: Add to Plan	No: Won't Add to Plan	N/A
Concept of Operations (Mitigation, Preparedness, Response, and Recovery)				
Plan identifies how health equity is included in the response (see Action 4: Activate Response Plan and Associated Annexes).				
Plan identifies a Health Equity subject matter expert (SME) as part of the response structure.				
The plan incorporates equity as an operational priority (see Action 4: Activate Response Plan and Associated Annexes).				
The plan describes how demographic and community data inform response and recovery decisions.				
The plan describes how the impact of response decisions on communities most impacted by disasters is incorporated during the response.				
The plan identifies and describes the use of situational awareness and information tools that can help identify and support communities most impacted by disasters in the region (see Action 4: Activate Response Plan and Associated Annexes).				
The plan provides resource allocation strategies that promote equitable access to resources.				
The plan includes planning and response strategies that attempt to minimize barriers to accessing medical care before, during, and after a disaster.				
Training and Exercise				
The plan's training section includes specifics on communities that are most impacted by disasters (see Action 6: Train and Educate).				
The plan's training programs are designed with health equity considerations (see Action 6: Train and Educate).				
The plan's exercise section tests specifics about communities that are most impacted by disasters (see Action 7: Design and Conduct Inclusive Exercises).				
The plan's exercises are designed with health equity considerations (see Action 7: Design and Conduct Inclusive Exercises).				

Appendix C: Inclusive Communications Guide

HPP Activity 3: Update Response Plan (Section 3.3.1, Page 27-29 of HPP FY24 NOFO)

Creating inclusive and accessible communications requires planning. Prior to completing the checklist below, consider the following questions to develop a more comprehensive understanding of the goal of the communication and who the communication is for:

Audience
☐ **Who is the audience? *** ○ Has this audience been communicated to before? ○ Are there known cultural, linguistic, or literacy factors that may influence how the audience receives the communication? ○ What are the barriers to communicating with the audience? *There may be more than one audience. Try to answer these questions for as many as possible. When crafting the communication, consider utilizing additional language and tools to make the communication accessible and inclusive to a wide range of individuals and communities.
Content
☐ **What is being communicated?** ○ Does the audience need to take a specific action? ○ Is this new information? ○ Does the communication contain life-saving or critical information?

Utilize the checklist below to create an accessible and inclusive message.

Accessibility *Allows the communication to be received and understood by as many people as possible.*
☐ **Use direct language** ○ When appropriate, use pronouns like “you” and “me” to make information more actionable to readers.
☐ **Use clear organization** ○ Use concise paragraphs and sentences and include the most important information first. ○ Utilize headers and bulleted lists. ○ Summarize key points at the end of a section/document.
☐ **Use clear language** ○ Use simple words and phrases and avoid jargon or technical language. ○ Limit the use of abbreviations and acronyms. ○ Provide the phonetical [fuh-net-i-kuhl] spelling of difficult words. ○ Provide translations of the communication in specific languages based on the audience or in as many languages as possible.
☐ **Use accessible formatting** ○ Follow organizational digital accessibility guidelines and standards.

Accessibility

Allows the communication to be received and understood by as many people as possible.

- If an organization does not have accessibility guidelines, refer to the Minnesota State Accessibility Standard.
- Use a larger font that is easier to read, such as a sans-serif font.
- Avoid fancy fonts, scripts, or italics.
- Avoid using all-caps.
- Bold font or use a different one for critical information.
- Microsoft Word has a built-in Accessibility Check. Utilize this to easily fix minor errors.
- Ensure compliance with Section 508 guidelines.

Inclusivity

Ensures the communication is open and clear to members of the audience based on gender, race, ethnicity, class, sexuality, disability etc.

Utilize **one or all** the following resources below to collect proper terminology and background information on specific audiences:

☐ **Documents/Guides**

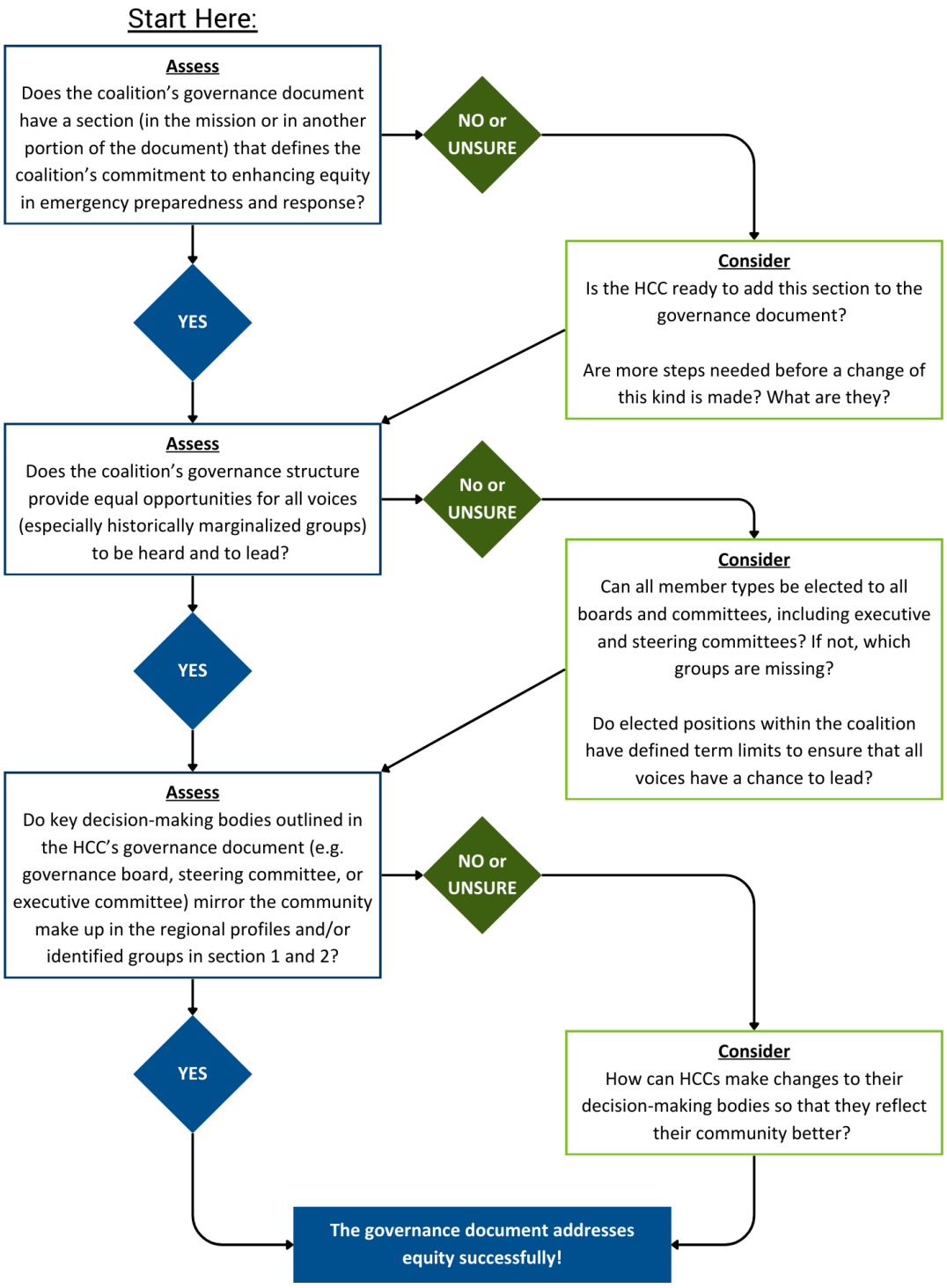
- American Psychological Association – Equity, Diversity, and Inclusion Inclusive Language Guide
  - Includes specific identity-related terms for age, body size and weight, disability, neurodiversity, race, ethnicity, culture, sexual orientation, gender identity, and socioeconomic status.
  - Includes additional guidance on how to avoid microaggressions in conversation and use culturally appropriate language.
- American Medical Association – Advancing Health Equity: A Guide to Language, Narrative and Concepts
  - Includes specific information about health equity specific language and why it's important to construct an equitable narrative.
  - Includes a glossary of equity-related terminology.

☐ **Webpages/Quick References**

- 18F (General Services Administration) – Inclusive Language Content Guide
  - Includes basic information about certain identity-related terms and communities.
  - Provides links to community-specific style guides.
- The Diversity Style Guide
  - Includes terms and phrases related to race/ethnicity, religion, sexual orientation, gender identity, age and generation, drugs and alcohol, and physical, mental, and cognitive disabilities.
  - Operates like a dictionary to find terms and read about their applications and history.
- American Psychological Association – General Principles for Reducing Bias

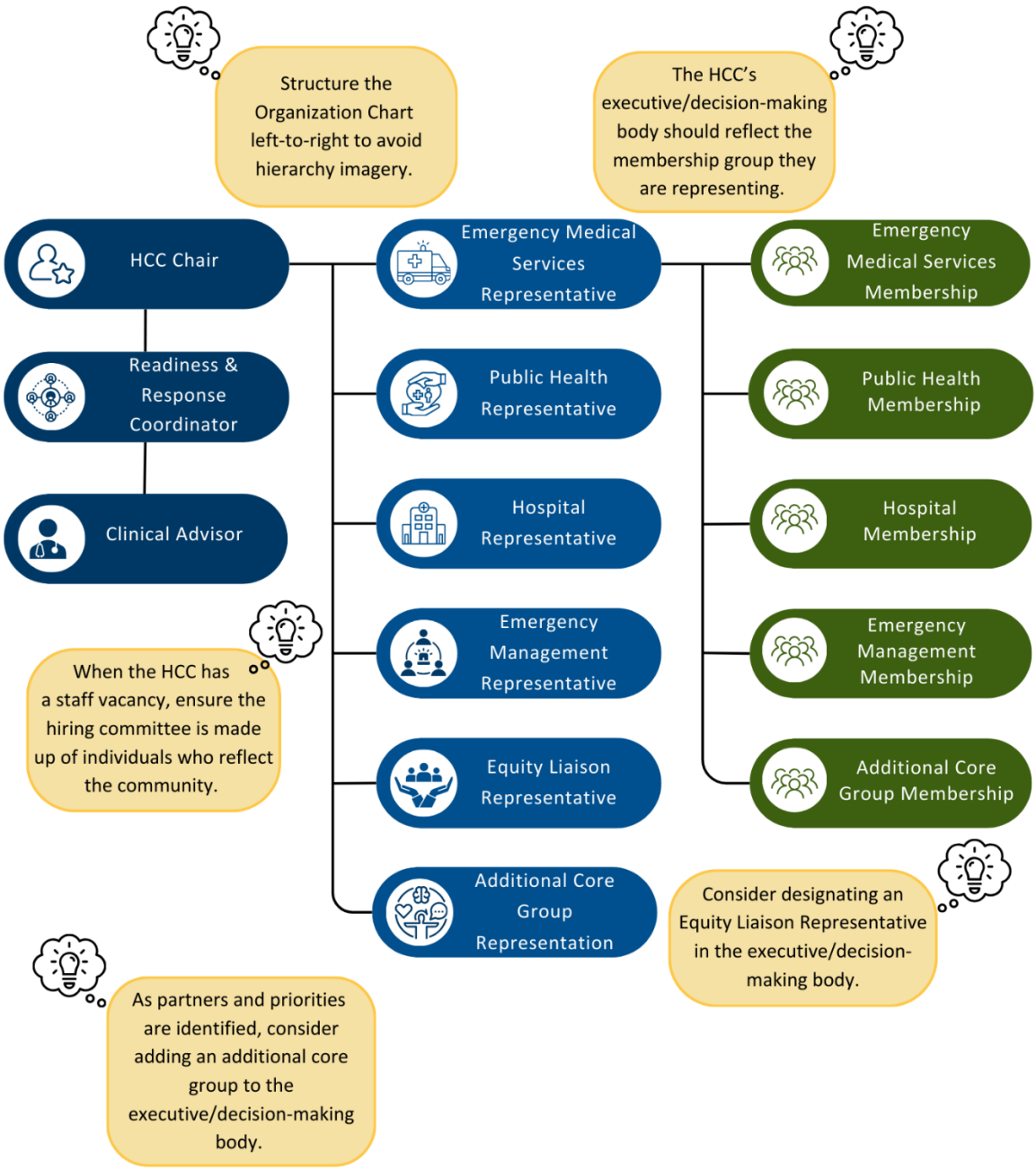
Inclusivity *Ensures the communication is open and clear to members of the audience based on gender, race, ethnicity, class, sexuality, disability etc.*
▪ Includes clear guidelines to quickly review when crafting a communication related to specificity and labels. ▪ Provides specific examples of how to apply these guidelines for different topics or communities. ○ Federal Emergency Management Agency – Using Inclusive Language ▪ Includes appropriate alternatives for commonly used inappropriate terminology. ▪ Specific to access and functional needs. ○ Centers for Disease Control and Prevention – Inclusive Communication Principles ▪ Includes key principles in inclusive communication and preferred terms. ▪ Also includes additional guidance on how to craft communications.

Appendix D: Governance Improvement Flowchart



HPP Activity 1 Governance: Update Governance to include how your HCC collaborates and engages with community partners and additional health care readiness partners in their jurisdiction (Section 1, Page 16-18 of HPP FY24 NOFO)

Appendix E: Sample Governance Organizational Chart



HPP Activity 1: Update Governance to include how your HCC collaborates and engages with community partners and additional health care readiness partners in their jurisdiction (Section 1, Page 16-18 of HPP FY24 NOFO)

Appendix F: Strategies to Strengthen Member Diversity

HPP Activity 1: Update Governance to include membership organizations that can help address disparities for communities most impacted by disasters (Section 1, Page 16-18 of HPP FY24 NOFO)

Does the HCC's membership represent the community make up in the Regional Profiles? If not, the following strategies can be used to increase the diversity of HCC members.

Action Item:

Using the HCC's Regional Profile, identify one or more demographic groups, especially groups with health disparities, that are missing at the HCC table. The HCC may want to address these gaps by communicating with and recruiting new members to the HCC. Remember that this recruitment process can be incremental. Pick one group to address at a time or employ one of the below recruitment strategies before trying another.

Each group with health disparities needs to be addressed differently to be included in HCC membership. In addition, relationship building with these groups will likely differ based on their unique barriers to engagement. Consider the following categories, as well as the strategies within. Would any of these strategies help to engage new groups in HCC work? If so, which one can the HCC commit to addressing first?

Analyze the following about the HCC:	
Start the Conversation	Of the communities most impacted by disasters identified from the Regional Profile, which ones are current members connected to already? Can any members, such as local public health, facilitate an introduction between a leader in one of these groups and the RHPC(s) of the HCC?
	What organizations in the region are already serving the group(s) the HCC wishes to engage? Keep a whole-community approach in mind when searching for these groups. Organization types may include: ○ Community centers. ○ Religious gathering centers. ○ Social service organizations. ○ Schools. ○ Health care and public health facilities providing targeted care (e.g. long term care providers, community clinics with a focus on the LGBTQIA2S+ community, Indian Health Service locations). ○ Refer to Appendix B of the HPP NOFO for additional health care readiness partners that may assist in this process.
	Are HCC materials, including member recruitment materials, available in languages other than English? If so, do those languages match the most common languages in the region?

Analyze the following about the HCC:	
Create an Accessible HCC	Are HCC materials, including member recruitment materials, accessible to individuals with access and functional needs? For example: ○ Are all materials available online? ○ Are all digital materials compatible with screen reading software? ○ Do HCC presentations and pre-recorded webinars include readable, unobscured captions?
	Are HCC meetings virtual (entirely or on a hybrid basis) to accommodate for individuals who may not have access to reliable transportation?
	For in-person events, are the venues accessible to all individuals regardless of mobility?
	Are HCC presentations and events seizure-safe (for example, are they pre-screened to remove flashing lights and rapidly flashing GIFs)?
Foster Safety in the HCC	Are group norms established within the HCC to ensure psychological safety of all members during meetings, trainings, and exercises?
	Do HCC presentations include warnings about distressing content?
	Do HCC members have a quiet place to step out and decompress during trainings and exercises?
	Are there gender neutral restrooms for transgender people, and people with disabilities?

Appendix G: Essential Elements of Information (EEI)

| HPP Activity 3: Develop or update a Continuity and Recovery Plan (Section 3.4, Page 33-36 of HPP FY24 NOFO)

Essential Elements of Information (EEI) are the critical pieces of information needed to assess and create a common operating picture about an incident or event. For Health Equity, EEI includes, but is not limited to, the following critical information about the community. Consider the general questions outlined in Table 1 below and then review Table 2 for specific considerations and potential accommodations for different populations that may reside within the community.

Table 1

Emergency EEIs	Health Equity Questions
Life-Saving Resources	Which community members have no access or limited access to life-saving resources?
	How can the HCC support widespread access to life-saving resources?
Public Information and Warning	Which community members could have no access, limited access and/or difficulty understanding emergency warnings and information?
	How can the HCC support widespread access and understanding of emergency warnings and information?
Critical Infrastructure Needs (e.g., transportation, utilities, communications services/systems, fuel supplies, and food/water supplies)	Which community members are disproportionately affected by impacts or damage to critical infrastructure?
	How can the HCC support disproportionately affected communities?
Critical Facility Needs (e.g., police stations, fire stations, medical providers, water/sewage treatment facilities, dams/levees, and chemical/hazmat facilities)	Which community members are disproportionately affected by impacts or damage to critical facilities?
	How can the HCC support disproportionately affected communities?

Emergency EEIs	Health Equity Questions
Needs of Displaced Individuals	Which community members have been displaced by the incident?
	How does the HCC support widespread access to emergency sheltering?
Resource Needs	Which community members require additional resources during an emergency?
	How does the HCC support widespread connection to resources?

Remember, individuals can be affected by multiple factors across many categories. Conversely, individuals within identified populations may not require any accommodation. This matrix is intended to highlight how certain factors may impact a particular population or individual and provide example considerations and accommodations that can be implemented into planning and response efforts.

Table 2

Factors	Population Examples	Potential Impacts	Potential Accommodations[xiii]
English as a Second Language	Households where 1+ member(s) do not speak and/or read English. Bilingual or multilingual households.	Inability or difficulty reading English-only emergency messaging. Translation is sought from family members (potentially children) who do not know specific medical or emergency jargon. Slower processing of emergency information due to translation time.	• Translate public messaging into dominantly spoken languages within the community. • Use plain, easily translatable language. • Implement website localization/translation. • Include visual/graphic imagery for emergency signage. • Utilize portable translation devices or translation services. • Partner with organizations that represent these communities to facilitate planning, training, and response efforts.
Immigrant and Refugee Populations	Refugees, Seasonal migrants, Immigrants, and/or	Lack of familiarity with local customs, medical language, or jargon.	• *See potential accommodations listed under English as a Secondary Language, Religious Affiliation, Insurance Access, Housing Security, and Vehicle Security and Access.*

Factors	Population Examples	Potential Impacts	Potential Accommodations[xiii]
	Undocumented people.	Lack of familiarity with navigational resources or emergency locations. Fear or hesitation to interact with law enforcement, military, or other government officials.	• Partner with organizations that represent these communities to facilitate planning, training, and response efforts. • Use spaces that are neutral, such as schools or community centers, as disaster assistance centers/shelters instead of armories or police stations. • Have non-uniformed response staff or volunteers available to interact with communities.
Sexual Orientation and Gender Identity[xiv]	LGBTQIA2S+ individuals.	Increased risks of poverty, discrimination, and underinsurance.	• *See potential accommodations listed under Insurance Access.* • Partner with organizations that represent these communities to facilitate planning, training, and response efforts. • Have gender neutral restrooms in places of public accommodation as well as gender-specific restrooms.
Educational Attainment	People without a high school diploma or GED.	Inability or difficulty accessing, reading, and/or understanding emergency messaging above a grade school reading level.	• *See potential accommodations listed under Poverty Level, Insurance Access, Housing Security, and Vehicle Security and Access.* • Use plain, easily understandable language. • Partner with organizations that represent these communities to facilitate planning, training, and response efforts.
Poverty Level	Rural communities. People with disabilities.[xv] Low-income workers.	Require access to public transportation or transportation assistance. Hesitancy to miss work for medical care.	• *See potential accommodations listed under Educational Attainment, Insurance Access, Housing Security, and Vehicle Security and Access.* • Partner with organizations that represent these communities to facilitate planning, training, and response efforts.

Factors	Population Examples	Potential Impacts	Potential Accommodations[xiii]
	Older adults.	Lack of access to clinics and hospitals. Inability to pay for medical care/uninsured or underinsured. Inability to seek emergency medical care or comply with evacuation orders.	
Religious Affiliation[xvi]	Amish. Buddhist. Hindu. Mennonites. Muslim. Orthodox Christian religions (i.e., Russian Orthodox). Sikh. Tribal belief systems.	Hesitancy to seek or oppositions to emergency medical care (e.g. blood transfusions, vaccines, etc.). Clothing requirements that prevent being uncovered in public. Need for prayer or worship spaces.	• Partner with organizations or community leaders that represent these communities to facilitate planning, training, and response efforts. • Cultural competency training for emergency responders that addresses the beliefs and practices of religious minority communities in the region.
Internet Security and Access	Rural communities. Low-income communities.	Limited access to emergency messaging disseminated via the internet (websites, social media, etc.)	• Ensure warnings and public messages are sent in multiple forms and through multiple channels. • Partner with organizations that represent these communities to facilitate planning, training, and response efforts.

Factors	Population Examples	Potential Impacts	Potential Accommodations[xiii]
Vehicle Security and Access	Urban Communities. Low-Income Communities.	Need access to public transportation or transportation assistance.	• Understand residency patterns and demographics ahead of emergencies. • Partner with organizations that represent these communities to facilitate planning, training, and response efforts.
Insurance Access[xvii]	Low-income communities. People who are uninsured or underinsured.	Hesitancy to seek emergency care. Inability to pay for medical care or prescriptions.	• Understand residency patterns and demographics ahead of emergencies. • Ensure emergency messaging disclose insurance coverage requirements (PODs, vaccination clinics). • Partner with organizations that represent these communities to facilitate planning, training, and response efforts.
Access and Functional Needs	Individuals with deafness or gearing disabilities.	Inability or difficulty hearing auditory commands or warning sirens. Inability to communicate verbally.	• Use accessible messaging formats (large print, braille, American Sign Language, closed captioning, audio descriptions, plain language). • Use plain, easily understandable language. • Ensure use of ADA-compliant buildings (shelters, vaccine clinics, PODs). • Understand residency patterns and demographics ahead of emergencies. • Partner with organizations that represent these communities to facilitate planning, training, and response efforts. • Connect to resources for durable medical equipment.
	Individuals with blindness or vision disabilities.	Inability or difficulty seeing visual commands or instructions and navigating unfamiliar places.	
	Individuals with physical/mobility disabilities.	Lack of access to accessible transportation. Inability to self-evacuate or move quickly.	

Factors	Population Examples	Potential Impacts	Potential Accommodations[xiii]
		Need spacious, accessible restrooms. Should be ADA compliant whenever possible. Need to stay with a companion or personal assistant. Cannot leave their mobility device behind or lost their mobility device during the emergency.	
	Individuals with mental/cognitive disabilities.	Inability or difficulty accessing, reading, and/or understanding emergency messaging. Inability to self-evacuate or move quickly. Need to stay with a companion or personal assistant. Sensory overload from chaotic or unfamiliar settings.	
Housing Security	Individuals living in congregate living	Increased risk of contagious diseases spread.	• Understand residency patterns ahead of emergencies.

Factors	Population Examples	Potential Impacts	Potential Accommodations[xiii]
	situations (Long Term Care Facilities (LTCF), student housing, etc.).	Additional transportation needs.	• Partner with organizations that represent these communities to facilitate planning, training, and response efforts.
	People experiencing homelessness.	No or limited access to standard warning systems. No or limited ability to access to shelter appropriate for emergency.	• Organized street outreach during emergencies. • Partner with organizations that represent these communities to facilitate planning, training, and response efforts.
Age	Adults age 65 and older.[xviii]	Increased risk of severe symptoms/outcomes from disease-related emergencies. Reside in LTCF, SNF, or other congregate living situations. Increased prevalence of mobility disabilities. Increased prevalence of chronic health conditions.	• *See potential accommodations listed under Housing Security and Access and Functions Needs.* • Connect to resources for durable medical equipment. • Understand residency patterns ahead of emergencies. • Partner with organizations that represent these communities to facilitate planning, training, and response efforts.
	Children age 18 or younger.[xix] [xx] [xxi]	Increased risk of severe symptoms/outcomes from some emergencies (e.g., chemical exposure). No or limited access to emergency warnings.	• Conduct responder training specific to children in disasters. • Understand residency patterns ahead of emergencies. • Ensure reunification plans are up-to-date and consider guardian/minor hand-off.

Factors	Population Examples	Potential Impacts	Potential Accommodations[xiii]
		Inability to communicate injuries. No or limited access to personal transportation. Limited pediatric-specific resources.	• Partner with organizations that represent these communities to facilitate planning, training, and response efforts.

Appendix H: Health Equity Officer Job Action Sheet

HPP Activity 3: Update Response Plan (Section 3.3, Page 27-29 of HPP FY24 NOFO)

Mission: Ensure adequate identification of communities in the region most impacted by disasters, specific risks, and response plans that address access, trust, and health equity within the facility and community. Review the ongoing response and recovery strategies and tactics for health equity and access issues.

Immediate	Time	Initial
• Receive appointment from the Incident Commander. • Read this entire Job Action Sheet and review the Situation Report or receive direct situational briefing from the Incident Commander. • Confirm with the Incident Commander any specific actions/issues to address or liaisons to establish based on the event. • Function as a resource for any health access or health equity concerns throughout the response. • Establish briefing schedule with the Operations Section Chief, Planning Section Chief, and Liaison Officer. • Document communications during shifts.		
Intermediate	**Time**	**Initial**
• Based on the incident, identify specific community groups at risk for inequitable access to resources, information, or likely to distrust the community and health care response. • Assist the Liaison Officer in identifying community liaisons with communities impacted by disasters that may provide insight into current issues and avenues for education about the response and available resources. • Assist the Planning Section Chief in reviewing the Incident Action Plan for potential health equity issues as well as advising on potential strategies and tactics to include that can improve access to information and medical care. • Assist the Public Information Officer in developing culturally and issue-appropriate talking points for use by the facility as and trusted members of the community groups. • Meet with affected unit supervisors to determine any necessary staff education based on the communities affected and identify any potential problem areas or issues.		
Extended	**Time**	**Initial**
• Collaborate with the Public Information Officer, Liaison Officer, and communications representatives to support health equity and access issue messaging on social media and local and national media. Work with Planning Section Chief to determine facility strategies to address these issues. Work with the Liaison Officer to support risk communications and interventions to the communities.		

• Determine specific issues for the communities most impacted by disasters as well as potential solutions. • Advocate with Incident Command and Planning Section for resources, strategies, and tactics to address deficits that may impair timely and appropriate care for the impacted community. • Develop talking points on religious and cultural practices for staff as appropriate to the incident.		
Demobilization/Recovery	**Time**	**Initial**
• Work with the Disaster Behavioral Health Program Coordinator to determine current and ongoing resources and solutions related to mental/behavioral health issues experienced by staff. • Identify community-based issues and potential recovery/mitigation solutions for inclusion in after-action analysis and future work plans. • Confer with Section Chiefs and line employees to identify any staff or systems issues within the facility that may need modification to improve access, health equity, or service to communities most impacted by disasters.		

Appendix I: Recovery Checklist

HPP Activity 3: Develop or Update a Continuity and Recovery Plan (Section 3.4, Page 33-36 of HPP FY24 NOFO)

Utilize the checklist below to ensure health equity has been considered throughout the recovery process. For more information, please see Action 5: Recover from an Incident.

Have specific populations/communities who may have been particularly affected by the recent event been considered?	
☐ **YES**	☐ **NO**
List populations: _____ _____ _____ _____ _____ _____ _____ _____	• Refer to Action 1: Understand the Region's Communities Most Impacted by Disasters. Think about groups to consider. • Review situational information and reports. • Host discussions with colleagues, to identify populations/communities that may have been disproportionately affected by this event.

If the answer to the above question is **YES**, continue answering the questions below:

Have diverse stakeholders and/or community-based organizations that serve those communities disproportionately impacted been engaged in the HCC recovery planning process?		
☐ **YES**	☐ **NO**	☐ **UNSURE**
Have these entities been included in communications and information-sharing?		
☐ **YES**	☐ **NO**	☐ **UNSURE**
Have these entities been included in After-Action Meetings and been provided pathways to share feedback?		
☐ **YES**	☐ **NO**	☐ **UNSURE**

Based on the questions and answers above, develop some action items. Examples could include identifying community-based organizations and sending out invites to organizations for After-Action Meetings.

Action Item 1: _____

Action Item 2: _____

Appendix J: Exercise Design and Conduct Considerations

HPP Activity 4: Plan and Conduct Exercises (Section 4, Page 36-39 of HPP FY24 NOFO)

The following tables outline considerations for designing, conducting, and evaluating exercises through an Inclusion, Diversity, Health Equity, and Accessibility (IDEA) lens[1]. While considerations are broken up into different exercise phases, it is useful to consider these questions throughout all phases of the project. The list of considerations is not exhaustive and is meant to be used as a guide for conducting inclusive and accessible exercises.

Getting Started: Exercise Design	
	Who lives in the community or exercise location/jurisdiction?
	What data sources are being used to collect data on community ahead of the exercise? (demographics, vital services, previously identified gaps, etc.)
	What community organizations, groups and/or leaders represent the affected group(s) identified above?
	Can the HCC engage with identified community organizations, groups, and/or leaders for input or participation in the exercise? *
	How can identified organizations be included in the design/conduct or the exercise? (planning, participation, evaluation, or observation roles)? *
	Have recent real-world events disproportionately impacted particular groups that can be incorporated into the current exercise? *
	If identified community organizations or leaders cannot be included in the exercise, can they be included in pre-exercise briefings or training leading up to the exercise?
	Are exercise planning meetings, trainings, and briefings accessible? Consider technology used (closed captions, interpretation, hybrid options), languages spoken/written, jargon used, location/spaces used (ADA compliance), etc.
	Will the exercise include an IDEA specific objective and/or capability?
	Have IDEA specific injects been developed to assist in meeting objectives/capabilities?
	What technology will be used/required during the exercise?
	What accommodations will be used/required during the exercise?
	What training is needed to educate personnel/participants about whole community needs, capabilities, and sensitivities?
For in-person exercises:	
	Will exercise registration ask about accessibility needs and accommodation requests? (parking, proximity to public transportation, food allergies/sensitivities, translation services, service animal accommodations).
	For virtual/hybrid meetings and exercises, will a virtual participation or technology guide be useful for participants?
	Do documents adhere to Section 508 guidelines? (exercise plans, PowerPoints, emails, etc.)

[1] IDEA lens explanation and more information can be found at: https://data.org/guides/intersectional-and-idea/

	Have the right players been invited to the table, including representatives of communities most likely to be impacted by this event?

Jumping In: Exercise Conduct	
	Does the facilitation style promote open dialogue and inclusion of all perspectives and voices? ("What is everyone's understating of _____?" "What does everyone else think?")
	Does the exercise offer multiple methods of participation (verbal, survey, and use of chat functions)?
	Does the exercise include participants from diverse backgrounds, lived experiences, and knowledge bases?
	Does the exercise include participants from the groups that will be impacted by the exercise scenario?
	Does the exercise include injects, questions, or discussion prompts about IDEA topics?
	Does the exercise incorporate the technology and accommodations identified during the planning stages?

Wrapping Up: Improvement Planning	
	Was the hotwash conducted in an accessible way and include feedback from all participants?
	Do preidentified participant feedback questions specifically ask about IDEA topics?
	What lessons were learned around IDEA topics during the exercise?
	Were any accommodations overlooked that should be implemented in future exercises?
	Were there any specific communities/groups left out of the exercise that should have been included?
	What corrective actions can be implemented moving forward?

*It is not always feasible or advisable to include community members or groups in certain exercises due to confidentiality or safety. When applicable, discuss how community members and/or community leaders can be incorporated into exercises:

- Can they review exercise materials ahead of time to provide input?
- Can they help develop and/or evaluate objectives?
- Can they participate as lived experience volunteers?
- Can they observe and participate in the exercise hotwash to provide feedback on exercise strengths and areas for improvements?

Appendix K: Exercise Scenarios and Injects

HPP Activity 4: Plan and Conduct Exercises (Section 4, Page 36-39 of HPP FY24 NOFO)

The Minnesota Department of Health developed three scenarios with corresponding injects that focus on health equity. These scenarios and injects can be used in exercises with Health Care Coalition members, local partners, and responders. The details of each scenario/inject, including locations and languages spoken, can be adjusted to match the regional characteristics of the exercise participants.

Following the three developed scenarios and corresponding injects, standalone inject examples have also been provided.

Scenario One – Biological Attack (noncommunicable):

Description:

The 2024 Republican and Democratic Presidential candidates visited Minnesota on the same day trying to win over voters. The GOP presidential candidate visited Hibbing in the Northeast region speaking at 4:30 pm at Bennett Park to a crowd of 7,000 ticketholders. The DFL presidential candidate visited Moorhead in the West Central region addressing a crowd of 10,000 students at the Minnesota State University Moorhead Campus on Scheels Field at 5:30 pm.

Later in the evening on the same day, breaking news reported that a disgruntled political party claimed responsibility of attacking those locations with agricultural aircrafts using aerial application to disperse anthrax spores on the crowds.

Early treatment with antibiotics, for people who may have been exposed to anthrax, is the best preventive measure since inhalation of anthrax can be very dangerous and has a high mortality rate.

The Minnesota Governor requested, and received approval for, the Strategic National Stockpile (SNS) for deployment of antibiotics. State and federal level public health emergencies have been declared. A Health Alert Network (HAN) notification has been sent to all local public health, tribal health departments, health care partners, and health care coalitions advising health care to be aware of patients presenting with symptoms consistent with inhalation anthrax and report suspected cases to MDH.

MDH held a conference call with the local public health and tribal health departments in the affected jurisdictions to request each county health and tribal health department activate one open Point of Dispensing (POD) to dispense antibiotic medication to the exposed population as soon as possible.

Local healthcare facilities in the affected jurisdictions are reporting a surge of calls from people in the community who believe they've been exposed to anthrax. Patients are also showing up in the emergency departments seeking medical attention.

MDH has activated the POD Provider Hotline to assist the Licensed Prescribing Consultant (LPC) at the local PODs in dispensing the correct antibiotic to the exposed people who may have complex health needs.

Corresponding Exercise Injects:	
1	A person with low vision needs a guide to escort them through the POD and is unable to use the written instructions that are handed out to affected individuals.
2	A Karen speaker with limited English proficiency is hesitant to receive treatment until she can talk to a doctor in her own language about her questions.
3	A deaf woman who communicates in American Sign Language has medical-related questions about dosing and side effects due to her existing medical condition.
4	An emergency manager tells the EOC that several community members who may have been at the rallies live in remote areas without broadband internet or television and asks what other kind of outreach is needed to reach them.
5	An older adult calls the POD and explains that they don't have transportation to get there from their home.
6	A transgender woman needs a private space for meeting her personal needs and reports harassment from a person at the POD.
7	An undocumented person is afraid to enter the POD because of the uniformed police at the POD's entrance.
8	An adult woman and her child, who appears to be around 9 years old, arrive at the POD for treatment. The adult relies on the child to translate spoken and written communication in English to Somali, which local public health staff know is not best practice for communicating medical information. How should local public health staff respond to the communication need?

Scenario Two – Power Outage:

Description:

An ice storm hits Minnesota spanning from Duluth south to the Twin Cities impacting high-voltage power lines causing a cascading series of electrical grid failures. It is mid-January, and the ice storm leaves more than 75% of homes, businesses, and health care facilities across Minnesota in the impacted areas without power. Electrical utility companies estimate at least 5 days will be needed to restore services.

Impact:

After two days, there have been 35 hospitalizations and seven deaths across Minnesota related to the power outage. There is a generator shortage. There are 40,884 people on Medicare/Medicaid identified as electrically dependent on power in MN with 17,706 of those identified residing in the seven-county metro area, and an additional 1,319 medically power dependent individuals in Carlton, Chisago, and Pine Counties. Several shelters using generators for power in the impacted areas have been opened to receive those without power. There have

been reports of many people using alternate heating and cooking sources which can have dangerous and lethal outcomes.

Corresponding Exercise Injects:	
1	A Tribal Nation is preparing to serve and shelter Tribal Members in the affected area. They predict that they will need a dozen more hospital beds and other medical supplies to meet the needs of their community and reach out to a neighboring county for assistance, as well as the Indian Health Service (IHS).
2	An older adult on waivered homecare services needs dialysis within one day but all the dialysis centers within 50 miles are shut down due to the power outage.
3	A family with a child undergoing chemotherapy runs out of specialized batteries for the child's medication pump.
4	Multiple African American older adults in a multistory apartment building have wheelchairs and walkers and cannot self-evacuate.
5	The son of one of the older adults calls the disaster assistance center from his home in the Dominican Republic looking for his father, who has dementia, and has not been able to reach him and is wondering if he is safe.
6	An asylum seeker with limited English proficiency gets separated from her husband and children after they were transported in different buses to the warming shelter and is trying to locate them.
7	An 88-year-old woman who is self-ambulatory in her home cannot move around without a mobility device in the warming shelter. She asks the shelter staff for a cane, walker, or wheelchair that she can use.
8	A resident in the affected area calls the warming shelter and asks if there is a refrigerator there where they can store their insulin. They do not have the means at home to keep the medication cold.

Scenario Three – Infectious Disease (naturally developing) Measles:

Description:

A 6-year-old unvaccinated child has been diagnosed with a case of measles. This has been confirmed through the MDH Public Health Laboratory. The child and their family recently arrived at a Hennepin County shelter two days ago, after spending a few weeks in an emergency shelter in southern Minnesota. The family consists of the mother and two siblings: a 9-month-old and a 3-year-old. The family is Spanish speaking.

It has been determined the child was infectious at both shelters; the one in Blue Earth County and in Hennepin County.

MDH has learned the following information from Hennepin County and Blue Earth County Public Health:

- The family has been living in isolation (in their own room) while at both Hennepin County and Blue Earth County, but had shared kitchen, bathrooms, and living space communally while in the Blue Earth County shelter.
- The current number of persons living in the Hennepin County shelter is 147 and in the Blue Earth County shelter is 84.
- The number of children in each shelter:
    - 67 in Hennepin County Shelter; and 32 in the Blue Earth County Shelter.
- Number of those children under 3 years of age:
    - Hennepin County- 23 children are under 3 years; Blue Earth County- 17 children are under 3 years old.
- What languages are spoken by the residents in the shelters?
    - Hennepin County: Spanish, Somali and Arabic, Amharic, and Oromo.
    - Blue Earth County: Spanish, Somali, and Swahili.

MMR vaccine will be given as routine vaccination to shelter residents without proof of vaccine. Immune globulin (IG) can be administered to young children up through day 6 after their first day of exposure to the infectious child. Children's Minnesota-Minneapolis has agreed to ask the parent of the child with measles if the sibling would like to get IG.

Northfield Hospital will collaborate with Blue Earth County Public Health to host clinics at the shelter in Blue Earth County.

Both counties will reach out to daycares and elementary schools that have hosted the family or child while infectious.

Corresponding Exercise Injects:	
1	An immigrant family refuses the vaccine due to fear that it will cause other medical problems for their children.
2	A Filipino woman with limited English proficiency whose children may have been exposed at daycare with children from the shelter wants her husband, who is at work, to be present for the assessment interview.
3	Undocumented children and adults in an under-staffed, over-crowded shelter only speak Spanish and cannot understand emergency messages or instructions in English.
4	A rumor begins circulating that the recommended treatment that is currently being offered in the shelter will cause infertility and breast cancer.
5	A teenager who is unvaccinated, homeless, and self-identifies as LGBTQIA+ wants to get the vaccine but needs permission, and they are not on speaking terms with their parents.
6	A woman and her unvaccinated Autistic daughter were exposed but her daughter needs time and privacy to get the shot. The daughter also needs to be accompanied by her service dog, which helps her feel calm.
7	A family in quarantine has no food or toiletries and does not have a personal support network that can help them. They call the county, asking for help

Additional Sample Health Equity Exercise Injects:

The following exercise injects are standalone elements that can be integrated into various exercises. They are designed to enhance health equity considerations, ensuring that these important factors are addressed in your exercise scenarios.

Standalone Scenario Exercise Injects:
A non-English speaking patient was unable to communicate effectively with healthcare providers.
A sight impaired person is amongst your incident casualties, how do you address the needs given you have limited first responders on scene.
An unhoused patient is ready for discharge, but the location they have been staying in is still an active incident. What is your process for discharging this patient?
A [insert at risk type] patient reveals mistrust in the healthcare system. How do you build trust?
A heatwave leads to a spike in heat-related illnesses, disproportionately affecting low-income communities that lack air conditioning. What are some strategies for addressing socioeconomic determinants of health during an emergency?
A natural disaster has occurred, and emergency shelters have been set up. Many of the affected individuals speak a language other than English and have difficulty understanding the instructions and accessing medical care. Explain your strategies to overcome this barrier.
A local pharmacy has been damaged, and residents are struggling to access essential medications, particularly for chronic conditions such as diabetes and hypertension. Evaluate the distribution plans for essential medications and support for chronic disease management in underserved communities.
A major public transportation strike coincides with a health crisis, making it difficult for low-income individuals to travel to medical facilities. Explain how your plans address this gap.
A culturally diverse community is experiencing a disease outbreak, and traditional public health messages are not resonating or being understood. Explain how you plan to adapt communication strategies.
An emergency has rendered several health facilities inaccessible to individuals with disabilities. Explain your contingency plans for ensuring that people with disabilities can access necessary medical care.
Following a traumatic event in a rural and underserved urban area, there is an increased demand for mental health services, but there is a shortage of providers. What is your plan to increase plan to provide equitable mental health support to the affected community?
A chemical emergency has occurred in an area known to contain a large, unhoused community. Explain your plan to monitor the adverse health effects of this community once recovery begins.

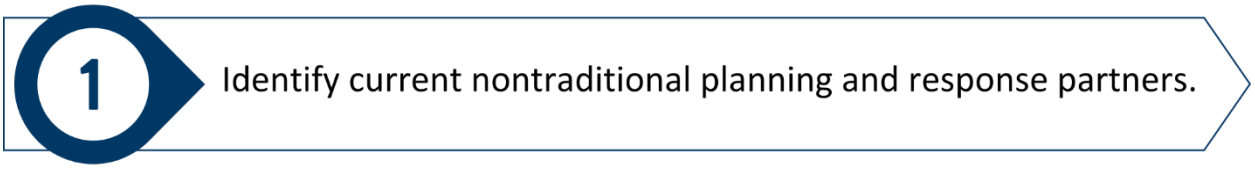
Appendix L: Champion a Healthy Equity Ecosystem for the Region

HPP Activity 2 Assess Readiness: Assess your region to identify populations most impacted by disasters (Appendix B, Page 87-89 of HPP FY24 NOFO)

Becoming a Health Equity Champion is one the keyways RHPCs can foster a health equity ecosystem in their region (see How Can an RHPC Foster a Health Equity Ecosystem?). Stepping into this role requires developing a new understanding of the whole community in a region. This requires proactive thinking about which communities have been historically left out and how they can now be included in planning for and responding to regional emergencies.

To accomplish this, preparedness and planning efforts must be improved. Individuals involved in this work are encouraged to keep an open mind, embrace curiosity, and be able to learn new things. These key skills will allow individuals to begin their journey towards becoming Health Equity Champions for their region.

Outlined below, there are eight steps to help guide individuals towards becoming a Health Equity Champion. These steps can be completed over time rather than all at once. Some may find it helpful to break this journey down into manageable pieces.



When prioritizing health equity in a region's plan, individuals should consider engaging with additional community groups to identify potential resource needs and barriers to access.

Some of these groups include:

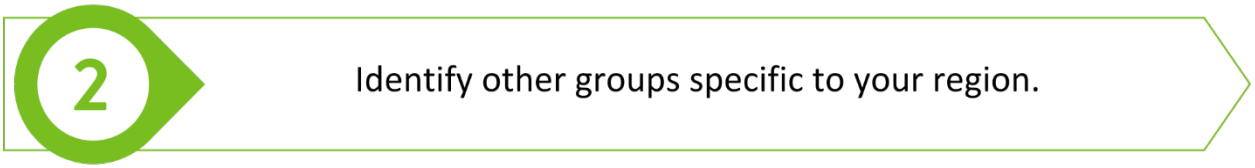
- Unhoused people
- Immigrants and refugees
- People with disabilities
- Rural communities
- People without transportation or with limited transportation or specific transportation support needs
- People who do not speak English
- LGBTQIA+ people
- African American people
- Asian/Pacific Islanders
- American Indian, Native American, Alaskan Native, and other Indigenous people
- Hispanic and Latino/a/x
- African Immigrants

- Older adults
- Children

The list above is not intended to be comprehensive. Instead, it serves as a starting point for individuals to consider as they move towards centering health equity in planning efforts.

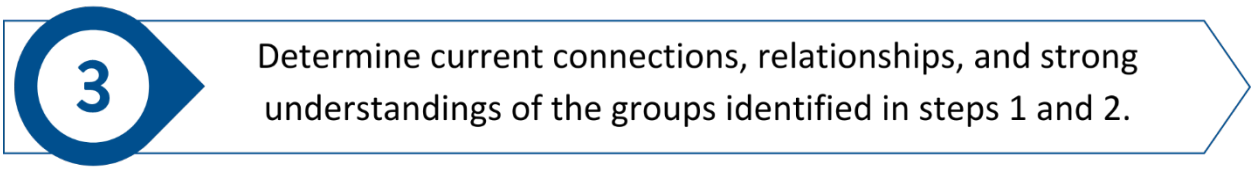
Of the groups above, which are already engaged in the planning process?

Brainstorm Notes:



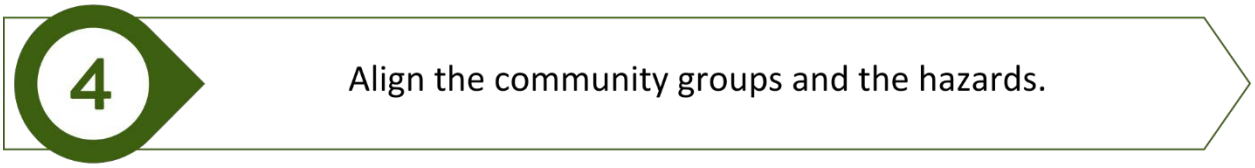
Regions should refer to their Regional Profile to start identifying additional community groups who may need to be engaged in HCC planning processes. Individuals should utilize other demographic, social vulvnerability, economic, and societal data points to continue to think critically about who else should be included in planning processes. Refer to Appendix O for references to appropriate data sources.

Brainstorm Notes:



Utilizing the data collected in the previous steps, individuals should think about whether any current connections, relationships, or agreements are already developed for the identified community groups.

Brainstorm Notes:



Individuals should think about the hazards likely to impact a region, then consider which communities are most likely to be impacted by these hazards. Individuals should look back on historical knowledge to complete this step.

Identify the top five groups in the region likely to be negatively impacted during an emergency.

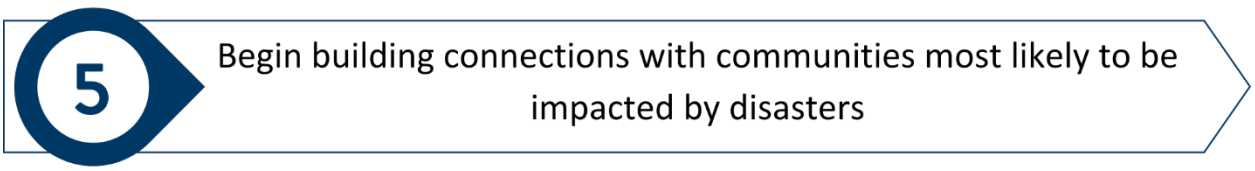
1.

2.

3.

4.

5.



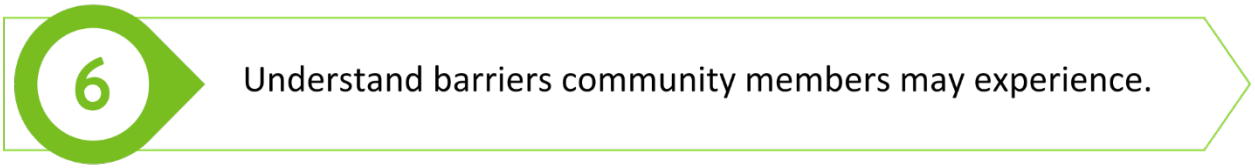
Identify actions and ways to engage with, build trust among, and better understand the needs of the community's groups by connecting with community organizations that serve and work with those communities.

Note - this step can be challenging and takes time and energy. It involves actively listening and being proactive about planning.

This step involves asking the right questions and thinking through considerations such as:

- What communities are likely to be impacted by a disaster in the region?
- What resources do they need?
- What evidence is there to support this resource need?
- Has this community been directly engaged regarding this type of hazard?
- Is there a process or organization in place to engage this community?
- Has this community's opinions and thoughts been listened to?
- Can this process be built into other planning work? Where? How?

Brainstorm Notes:



Differences in lived experiences, social and physical environments, education, transportation, and financial concerns can create obstacles to taking proactive health measures or accessing healthcare during an emergency. It is crucial to understand how these barriers affect different communities.

There are a number of barriers to access. Using vaccination access is an easy example that many people can relate to from their COVID-19 response experiences. Some examples of vaccine access barriers include, but are not limited to:

- Information about how to get vaccinated is hard to understand or find.
    - Accessing this information requires internet access and technology literacy.
- Vaccination site locations are inconvenient, hard to access or in places not trusted by some community groups.
- The systems and institutions performing vaccination may not be trusted, due to historical actions and behaviors.
- Accessing vaccines has costs, even though vaccines themselves are free.[xxii]

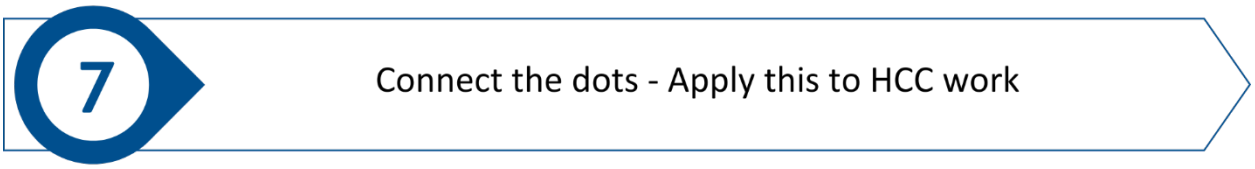
Proactively identifying barriers to access can help put in place mitigation efforts to reduce or eliminate those barriers. This is why it is important to understand them and identify them ahead of time in the planning process.

Think about past emergency responses. Consider the following questions:

- What barriers did communities in the region experience?
- What support is needed in mitigating or addressing those barriers moving forward?
- What questions need to be asked to proactively address these barriers in future planning and response efforts?

Brainstorm Notes:

For more information on how to plan to address those barriers, see the Planning Considerations Checklist in Section Two of this Toolkit.



HCCs play a role in improving the health equity ecosystem in five key areas:

- Resource Coordination
- Information Sharing
- Training and Education
- Exercises
- Champions of Social Change

Where can health equity be embedded in those key areas?

Below are some questions to consider when thinking through creating a health equity ecosystem in HCC work:

Key Area	Concept Application Questions
Resource Coordination	Where are resources most likely to be needed? What are those resources? What planning efforts can be put in place for equitable distribution of those resources in advance?

Key Area	Concept Application Questions
Information Sharing	Think about the information sharing systems in the region: websites, email, mass notification systems, meetings, and applications. Then, think about how to make those systems more inclusive for diverse end-users. Also, what questions are not currently being asked to ensure that the right information is asked and shared?
Training and Education	What opportunities are there to implement training and education for members on what health equity is, why it is important, and how they can begin to think about doing it in their own day-to-day work? What partners can be engaged to assist in this training and education? What community groups can provide training for membership to expand their understanding of cultural considerations, needs, and wants of community groups in the region? Are there opportunities to provide trainings through different platforms or in different languages (other than English) to expand the workforce?
Exercises	Do exercise scenarios mirror real life? Do they include communities most likely to be impacted by disasters in the region? How can exercises be made more realistic and inclusive?
Health Equity Champion	Individuals have power and influence in what their region discusses and what is prioritized in emergency preparedness planning, training, and exercising in the region. They can use their power and influence to be a Health Equity Champion. How can health equity be better incorporated into current HCC work? How can others be influenced to engage with this work? What spheres of influence exist? How can power be leveraged to make improvements in the region?

Individuals should brainstorm with their peers, state, or local subject matter experts to identify action items and next steps in this process.

Identify **three actions** to begin embedding health equity in HCC work:

1.

2.

3.

8 Educate, elevate, and embed health equity to act as a Health Equity Champion for the region.

Embedding health equity principles and best practices requires creating new behaviors and actions in everyday tasks. Doing this every day helps to build muscle memory so these same considerations can become more automatic when an emergency happens. Individuals should educate themselves and others to help reinforce these patterns.

Identify **three opportunities and/or trainings** to help educate partners, stakeholders, or HCC members in existing work:

1.

2.

3.

Appendix M: HPP NOFO Health Equity Crosswalk

At the time of the writing of this Toolkit, NOFO Capabilities have not been clearly tied to HPP Activities. The second column of this document is All Clear's best guess about how Capabilities will tie to Activities, pending more guidance from ASPR. This may change as new guidance becomes available.

HPP Activities	Anticipated Associated Capability	NOFO Language	Location within NOFO
Assess your region to identify populations most impacted by disasters.	Capability 1: Foundation for Health Care and Medical Readiness	Other populations disproportionately impacted by disasters in your jurisdiction, identified through data collection or assessments. • See Appendix B of NOFO for resources to identify the communities.	Pg. 87 – 89
Update governance to include membership of organizations that can help address disparities for communities most impacted by disasters.	Capability 1: Foundation for Health Care and Medical Readiness	Your HCC(s) should strive to make strategic membership decisions based on expertise needed to accomplish the following: carry out the core functions, address readiness gaps (for example, gaps identified through assessments), and meet the needs of the communities your HCC serves, including communities most impacted by disasters.	Pg. 16 – 18
Update governance to include how your HCC collaborates and engages with community partners and additional health care readiness partners in their jurisdiction.	Capability 1: Foundation for Health Care and Medical Readiness	You must demonstrate how your HCC improves community coordination and engagement by identifying the communities most impacted by disasters and their health care needs within the area your HCC serves. ASPR requires that your HCC specify the datasets or other inputs they used to identify these communities include community organizations that represent and/or serve communities most impacted by disasters. As you conduct activities (e.g., develop plans) related to addressing the needs of communities most impacted by disasters, you must collaborate with Public Health Emergency Preparedness (PHEP) cooperative agreement recipients and other relevant partners.	Pg. 16 – 18

HPP Activities	Anticipated Associated Capability	NOFO Language	Location within NOFO
Conduct an HVA	Capability 1: Foundation for Health Care and Medical Readiness	Assess readiness by conducting an HVA- using partners from impacted communities and databases such as SVI and emPower	Pg. 19 – 20
Conduct a Supply Chain Integrity Assessment	Capability 1: Foundation for Health Care and Medical Readiness	Assess the readiness by conducting Supply Chain Integrity Assessment- Impact on communities. Describe the anticipated impact of potential supply chain shortfalls on communities most impacted by disasters.	Pg. 20 – 21
Conduct a Workforce Assessment	Capability 1: Foundation for Health Care and Medical Readiness	Describe the anticipated impact of potential workforce shortfalls on communities most impacted by disasters. Describe existing mitigation strategies to address potential workforce shortfalls.	Pg. 21 – 22
Conduct a Cybersecurity Assessment	Capability 1: Foundation for Health Care and Medical Readiness	Describe the impact of a potential cyber incident on communities most impacted by disasters. Identify mitigation strategies. Based on the ten essential HPH Sector Specific Cybersecurity Performance Goals (CPGs), determine where your HCCs may have gaps and identify mitigation strategies that will address these priority areas for cyber preparedness and resiliency.	Pg. 22
Conduct an Extended Downtime Health Care Delivery Impact Assessment	Capability 1: Foundation for Health Care and Medical Readiness	This assessment is at the HCC level (understood to be at the FA and HCC operational level), not for individual HCC members. Describe the impact of a potential downtime event on communities most impacted by disasters.	Pg. 23
Develop a Strategic Plan for FY 2024-2028	Capability 1: Foundation for Health Care and Medical Readiness	The plan must include a description of the community organizations that represent or serve communities most impacted by disasters that you plan to engage to address your top priorities during the period of performance.	Pg. 24 – 25

HPP Activities	Anticipated Associated Capability	NOFO Language	Location within NOFO
Develop a Readiness Plan	Capability 1: Foundation for Health Care and Medical Readiness	Address gaps identified through assessments. Note: This section can be updated on a rolling basis as you and your HCC(s) complete assessments and identify areas for improvement. • Engaging community partners. Include gaps identified for communities most impacted by disasters.	Pg. 25 – 26
Update Training and Exercise Plan	Capability 1: Foundation for Health Care and Medical Readiness	Based on priorities identified in the Strategic Plan and Readiness Plan, describe how you and your HCC(s) will select which trainings and exercises to conduct that address communities most impacted by disasters. Include representation from communities most impacted by disasters in planning and identifying trainings and exercises.	Pg. 26 – 27
Update Response Plan	Capability 2: Health Care and Medical Response Coordination	You must identify and use situational awareness and information tools that can help identify and support communities most impacted by disasters in your jurisdiction.	Pg. 27 – 29
Update or develop a Resource Management Plan	Capability 2: Health Care and Medical Response Coordination	Include information from Supply Chain Assessment related to communities most impacted by disasters.	Pg. 29 – 30
Develop a Workforce Readiness / Resilience Plan	Capability 2: Health Care and Medical Response Coordination	Include information from the Workforce Assessment pending further guidance and templates.	Pg. 30
Develop or update Medical Surge Support Plan	Capability 4: Medical Surge	Each BP, HCC(s) must assess gaps and priorities related to the medical surge plan to refine and update annexes as needed for specialty surge events, including but not limited to – pediatric, burn, special pathogen, chemical, and radiological. Include	Pg. 30

HPP Activities	Anticipated Associated Capability	NOFO Language	Location within NOFO
		information gathered in assessments that relate to communities most impacted by disaster. • Refer to Appendix A of the NOFO: Additional Activity Detail for additional information about this requirement.	
Allocation of Scarce Resources Plan- should be at the recipient level	Capability 2: Health Care and Medical Response Coordination	Community and provider engagement, education, and communication activities (completed and planned). The HCC must engage community partners that represent communities most impacted by disasters. • This should be a recipient-level activity; however, states may require this at the HCC level.	Pg. 33
Plan and Conduct Exercises	Capability 1: Foundation for Health Care and Medical Readiness	Account for the unique needs of local health care organizations and communities most impacted by disasters in exercises and reports. include representation from communities most impacted by disasters in planning for exercise	Pg. 36 – 39
Develop or update a Continuity and Recovery Plan	Capability 3: Continuity of Health Care Service Delivery	• No NOFO language but plans should account for the unique needs of communities most impacted by disaster	Pg. 33 – 36

Appendix N: Educational Resources

Equity Training and Educational Resources

- Advancing Health Equity
  - Training – Advancing Health Equity (https://advancinghealthequity.com/training/)
- Centers for Disease Control and Prevention (CDC)
  - Foundations of Health Equity Training Plan (https://www.train.org/cdctrain/training_plan/6335)
  - From Concepts to Practice: Health Equity, Health Inequities, Health Disparities, and Social Determinants of Health (https://www.train.org/cdctrain/course/1061047/details)
- Association of American Medical Colleges (AAMC)
  - Diversity and Inclusion Video Learning Series (https://www.aamc.org/what-we-do/equity-diversity-inclusion/learning)

Community Engagement Resources

- Center for Wellness and Nutrition
  - Community Engagement Toolkit: A Participatory Action Approach Towards Health Equity and Justice (https://centerforwellnessandnutrition.org/wp-content/uploads/2020/02/FINAL-COMMUNITY-ENGAGEMENT-TOOLKIT_-Upd2282020.pdf)
- Boston Public Health Commission
  - Equitable Community Engagement Toolkit (https://www.boston.gov/sites/default/files/file/2021/03/BPHC Community Engagement Toolkit 2_Final.pdf)
- Simon Fraser University's Morris J. Wosk Centre for Dialogue
  - Beyond Inclusion – Equity in Public Engagement: A Guide for Practitioners (https://www.sfu.ca/content/dam/sfu/dialogue/ImagesAndFiles/ProgramsPage/EDI/BeyondInclusion/Beyond Inclusion - Equity in Public Engagement.pdf)
- Hartford Public Library
  - We Belong Here – An Initiative for Immigrant and Community Engagement (https://welcomingamerica.org/wp-content/uploads/2021/01/HPL_We-Belong-Here-Toolkit.pdf)
- Minnesota Department of Health (MDH)
  - Evaluation and Recommendations for Emergency Communication Strategies to reach Limited English Proficient Populations (https://www.health.state.mn.us/communities/equity/reports/emercommlep0612.pdf)

Planning Resources

- Welcoming America, Institute for Diversity, and Inclusion in Emergency Management
  - Establishing and Maintaining Inclusive Emergency Management with Immigrant and Refugee Populations (https://welcomingamerica.org/wp-content/uploads/2021/04/Inclusive-Emergency-Management-Checklist.pdf)
- Federal Emergency Management Agency (FEMA) and American Red Cross
  - Preparing for Disaster for People with Disabilities and other Special Needs (https://www.redcross.org/content/dam/redcross/atg/PDF_s/Preparedness___Disaster_Recovery/General_Preparedness___Recovery/Home/A4497.pdf)
- Centers for Disease Control and Prevention (CDC)
  - To Define, Locate, and Reach Special, Vulnerable, and At-risk Populations in an Emergency (https://emergency.cdc.gov/workbook/pdf/ph_workbookfinal.pdf)
  - Community Assessment for Public Health Emergency Response (CASPER) Toolkit (https://www.cdc.gov/nceh/casper/docs/CASPER-toolkit-3_508.pdf)
  - Planning for an Emergency: Strategies for Identifying and Engaging At-Risk Groups (https://www.cdc.gov/nceh/hsb/disaster/atriskguidance.pdf)

Recovery Resources

- ASPR Technical Resources, Assistance Center, & Information Exchange (TRACIE)
  - Healthcare Coalition Recovery Plan Template (https://files.asprtracie.hhs.gov/documents/aspr-tracie-hcc-recovery-plan-template.pdf)
  - Equitable Disaster Recovery Assessment Guide & Checklist Advancing Equity in Post-Disaster Recovery Operations (https://files.asprtracie.hhs.gov/documents/final-equitable-disaster-recovery-assessment-guide-and-checklist.pdf)
- Federal Emergency Management Agency (FEMA)
  - Achieving Equitable Recovery (https://www.fema.gov/sites/default/files/documents/fema_equitable-recovery-post-disaster-guide-local-officials-leaders.pdf)
- World Bank
  - Disability-Inclusive Disaster Recovery (https://documents1.worldbank.org/curated/en/265011593616893420/pdf/Disability-Inclusive-Disaster-Recovery.pdf)

Exercise Resource

- Federal Emergency Management Agency (FEMA)
  - Inclusion, Diversity, Equity and Accessibility in Exercises (https://www.fema.gov/sites/default/files/documents/fema_inclusion-diversity-equity-accessibility-exercises.pdf)

Appendix O: Supplemental Data Sources

Data Source	Description
Amish America – Minnesota Amish	This website (https://amishamerica.com/minnesota-amish/) provides information on the population growth of Minnesota's Amish population over the past four decades.
Amish Studies – The Young Center	This resource (https://groups.etown.edu/amishstudies/) offers maps, bar graphs, and tables that detail population data of the Amish population by state and province as of 2023.
Diversity Index – 2020 Census Data	This data (https://www.census.gov/library/visualizations/interactive/racial-and-ethnic-diversity-in-the-united-states-2010-and-2020-census.html) provides information on the racial and ethnic compositions and diversity of the U.S. population as of April 1, 2020. The data is expressed as prevalence rankings, diffusion scores, and prevalence mapping.
Migration Policy Institute	This data (https://www.migrationpolicy.org/programs/migration-data-hub) profile provides historical data relating to language and education proficiencies of foreign-born and U.S.-born populations in Minnesota.
Minnesota Compass County Profiles	This webpage (https://www.mncompass.org/profiles/county) provides population numbers for each county in Minnesota.
Minnesota Department of Human Services – Medicaid and MinnesotaCare	This webpage (https://mn.gov/dhs/people-we-serve/adults/health-care/health-care-programs/programs-and-services/minnesotacare.jsp) provides a breakdown of the enrollment in Medicaid and MinnesotaCare by Minnesotans throughout the COVID-19 pandemic.
Minnesota Health Equity Assessment	This report (https://www.health.state.mn.us/communities/practice/healthymnpartnership/sha.pdf) is an assessment of the systems and structures relating to health throughout the state of Minnesota.
Minnesota Homeless Study	This study (https://www.wilder.org/mnhomeless/results) was completed in 2023 with the purpose of analyzing a subset of the overall LGBTQ people in Minnesota who were experiencing homelessness.
Minnesota Indian Affairs Council	This MDH webpage (https://mn.gov/indian-affairs/) details the locations of the historical homelands of the eleven American Indian populations in Minnesota.

Data Source	Description
Minnesota Public Health Data Access	This website (https://data.web.health.state.mn.us/home)data tracking the number of people in Minnesota who live in poverty. The available data shows trends in the poverty level since 2005.
Minnesota Public Health Data Access – Health Insurance	This webpage (https://data.web.health.state.mn.us/insurance) provides statistics on the prevalence of health insurance in Minnesota. The data is broken down into categories including by type, by region, by race or ethnicity, by age, and by sex.
Minnesota State Demographic Center – The Economic Status of Minnesotans 2023	This report (mn.gov/admin/assets/Economic%20Status%20of%20Minnesotans%202023_tcm36-569572.pdf) was prepared by the Minnesota State Demographic Center. This report presents data relating to the economic conditions and considerations of Minnesotans.
Native Land Digital	This interactive map (https://native-land.ca/) is an educational tool that acts as a visual representation of Indigenous history.
Poverty in Minnesota Counties	This interactive map (https://hdpulse.nimhd.nih.gov/data-portal/social/table?socialtopic=080&socialtopic_options=social_6&demo=00008&demo_options=poverty_3&race=00&race_options=race_7&sex=0&sex_options=sex_3&age=001&age_options=ageall_1&statefips=27&statefips_options=area_states) of Minnesota provides information relating to the state poverty levels broken down by individual counties.
Rural Health Care in Minnesota: Data Highlights	This document (https://www.health.state.mn.us/facilities/ruralhealth/docs/summaries/index.html) provides details relating to the demographic characteristics of rural Minnesota, the structure of the rural health system, the rural health system workforce, health care use in rural Minnesota, and financing for rural health care.
Rural Health Information Hub	This webpage (https://www.ruralhealthinfo.org/) is a collection of resources that provide data and demographic information for the different populations that live in Minnesota.
The Social Vulnerability Index (SVI)	This webpage (https://www.atsdr.cdc.gov/place-health/php/svi/) offers details relating to the Social Vulnerability Index. Content on this page includes an interactive map, data and documentation, publications and materials, and a fact sheet.

Data Source	Description
State Health Access Data Assistance Center (SHADAC)	This tool (https://www.shadac.org/state) provides data on uninsured rates and counts of Minnesotans at the ZIP code, county, economic development region, MNSure rating area, legislative district, and state level.
UCLA School of Law Williams Institute	This website (https://williamsinstitute.law.ucla.edu/visualization/lgbt-stats/#density) provides data relating to the LGBT proportion of the population within Minnesota. The data covers topics such as characteristics of LGBT people, socioeconomic indicators, and LGBT percentage of populations within Minnesota comparative to other states.
United States Census Profile - Minnesota	This interactive map (https://data.census.gov/profile/Minnesota?g=040XX00US27) provides census data for the populations and people of Minnesota.

Appendix P: Stories from Minnesota Community Members

The following pages contain stories from diverse community members throughout Minnesota and focus on each individual's personal experience with the health care system. These stories are designed to help users learn more about Minnesotans' varying experiences when accessing the health care system. These stories can be used together or as standalone documents to support training and understanding of why health equity centered planning matters. Each story contains specific recommendations to support these processes.

Attachment A: Acronyms

Acronym	Definition
AFN	Access and Functional Needs
ASPR	Administration for Strategic Preparedness and Response
CHW	Community Health Worker
CMS	Centers for Medicare and Medicaid
DHHS	Department of Health and Human Services
EEI	Essential Element(s) of Information
EPR	Emergency Preparedness and Response
FEMA	Federal Emergency Management Agency
FQHC	Federally Qualified Health Center
HCC	Health Care Coalition
HPP	Hospital Preparedness Program
HVA	Hazard Vulnerability Analysis
ICS	Incident Command System
JRA	Joint Risk Assessment
LGBTQIA2S+	Lesbian, Gay, Bisexual, Transgender, Questioning/Queer, Intersex, Asexual/Aromantic, and Two-Spirit Community. *Note: The + at the end of "LGBTQIA2S+" is used to indicate that members of this community may use gender, sex, sexuality, or romantic attraction labels that are not explicitly mentioned in the "LGBTQIA2S" portion of this acronym.*
MDH	Minnesota Department of Health
NOFO	Notice of Funding Opportunity
RHPC	Regional Health Care Preparedness Coordinator
WIC	Women, Infant, and Children

Attachment B: References

[1] Sometimes referred to as the Social "Drivers" of Health: https://www.nachc.org/topic/social-drivers-of-health/
[2] Healthy People 2030, U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. Retrieved from https://health.gov/healthypeople/objectives-and-data/social-determinants-health
[3] Cash-Gibson et al., 2018. https://www.sciencedirect.com/science/article/abs/pii/S0149718921000811
[4] Social Determinants of Health - Healthy People 2030 | health.gov
[5] https://www.rwjf.org/en/insights/our-research/infographics/visualizing-health-equity.html
[6] https://aspr.hhs.gov/at-risk/Pages/default.aspx
[7] Ibid.
[8] ASPR, 2024
[9] US House of Representatives Committee on Homeland Security Hearing "Ensuring Equity in Disaster Preparedness, Response, and Recovery" (Oct 27, 2021) https://www.congress.gov/117/meeting/house/114141/witnesses/HHRG-117-HM00-Wstate-PeekL-20211027.pdf.
[10] Ibid.
[11] https://www.jointcommission.org/-/media/tjc/documents/standards/r3-reports/r3_disparities_july2022-6-20-2022.pdf
[12] https://www.cms.gov/priorities/health-equity/minority-health/equity-programs/framework
[xiii] (Centers for Disease Control and Prevention, 2022)
[xiv] (Nephrol, 2022)
[xv] (Farrigan, 2020)
[xvi] (Swan, 2020)
[xvii] (Ruohua Annetta Zhou, 2018)
[xviii] (Centers for Disease Control and Prevention, 2021)
[xix] (The National Child Traumatic Stress Network, n.d.)
[xx] (The National Child Traumatic Stress Network, n.d.)
[xxi] (Centers for Disease Control and Prevention, 2020)
[xxii] https://www.rand.org/pubs/research_reports/RRA1627-1.html